PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

1988 ADJUSTMENTS TO THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

REPORT TO THE CONGRESS

NOVEMBER 1987

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ASSESSMENT COMISSION

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-ProPAC-

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Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

November 30, 1987

President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

I am hereby transmitting a report by the Prospective Payment Assessment Commission on the adjustments made by the Secretary, Department of Health and Human Services for the fiscal year 1988 Medicare prospective payment system. This report is provided as required by Section 1886(d)(4)(D) of the Social Security Act as amended by Public Law 98-31.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

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Speaker
U.S. House of Representatives
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NOVEMBER 1987 REPORT TO CONGRESS

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EXECUTIVE SUMMARY

Introduction

The Prospective Payment Assessment Commission (ProPAC) was created to assist Congress and the Department of Health and Human Services in the monitoring and updating of the prospective payment system (PPS). ProPAC is an independent, legislative Commission. Seventeen members, knowledgeable in the areas of health care financing, delivery, and research, serve on the Commission. ProPAC submits three annual reports. In this report to Congress, ProPAC analyzes and evaluates the Secretary's September 1, 1987 final Medicare PPS regulations for fiscal year 1988.

The Commission has examined a number of areas in PPS policy critical to the optimal functioning of the system. We have brought these areas of concern to the attention of the Secretary and Congress in our reports. The Secretary has made some important adjustments to PPS which we believe are essential. In other areas, the Congress has legislated changes necessary to ensure the effective delivery of hospital care to Medicare beneficiaries and access to such care. Still, we believe other changes are needed to improve the distribution of payments and to assure that PPS responds to new and developing technologies and changing medical practice patterns.

The Commission's recommended adjustments to PPS fall into two broad categories. The first relates to the annual change in payments to hospitals -- the update factor. The second concerns changes in technologies, case mix, and coding. The Commission's concern for quality of care and other beneficiary interests permeates both of these areas.

This summary highlights the major PPS payment issues addressed by the Secretary for fiscal year 1988.

Update Factor and Payment Amounts

UPDATE FACTOR: In the Omnibus Budget Reconciliation Act of 1986, Congress set the amount by which payment rates would increase for fiscal years 1987 and 1988. The update factor for PPS and PPS-exempt hospitals was set at 1.15 percent for fiscal year 1987 and at a percentage increase equal to the market basket minus two percent for fiscal year 1988. Congress, however, delayed implementation of this update factor and extended fiscal year 1987 rates from September 30, 1987 through November 20, 1987. It therefore appears that Congress may legislate a different update factor for the remainder of fiscal year 1988.

The final regulations published by the Secretary include the required update of market basket minus two percent, or 2.7 percent. The Secretary, however, recommended much lower update factors of 0.75 percent for PPS hospitals and 1.9 percent for PPS-exempt hospitals and units for fiscal year 1988. The Commission recommended an average update of 2.3 for PPS hospitals and 4.2 for PPS-exempt hospitals and units. The Commission believes that the update factors recommended by the Secretary are too stringent and could adversely affect some hospitals and the Medicare beneficiaries treated.

The Commission develops numerical estimates for each component of the update factor. In each of its annual recommendations, the Commission has presented the methodology used to develop this factor with supporting data.

In the past, the Secretary has relied on a similar approach in calculating the update factor. Departing from this approach, however, the Secretary presented a rather general discussion of the philosophy of fiscal constraint in arriving at his recommended amounts for fiscal year 1988. Supporting evidence was not presented. Without such information, the reasonableness of the Secretary's recommendation cannot be critically evaluated. In any case, the Commission believes that the amounts proposed by the Secretary are inappropriately low.

The Commission's update factor recommendation contained two additional components which were not recognized by the Secretary. ProPAC examined recently available first-year PPS cost data and found that payment rates computed using these data would be 12.3 percent lower than current rates. ProPAC believes that part of this difference has already been accounted for in relatively low update factors since the first year of PPS and that productivity gains should be shared with the hospital industry. As a result the Commission's recommendation includes a 5.4 percent reduction in the update factor, to be phased in equally at 1.8 percent over three years.

First-year PPS cost data also demonstrated significant differences in current and recalculated standardized amounts between urban and rural hospitals. To account for these differences, the Commission recommended separate update factors for urban and rural hospitals -- 2.2 percent and 3.0 percent, respectively. The Secretary did not agree with these approaches.

LABOR MARKET AREAS: The Commission recommended that the Secretary adopt improved definitions of hospital labor market areas for urban and rural areas. The definitions for urban areas should distinguish

between central cities and outlying areas and for rural areas they should distinguish between urbanized rural areas and other rural areas.

The Secretary rejected this recommendation arguing that HCFA's research indicated that its adoption would result in abrupt changes in the distribution of payments. The Commission believes, however, that the intent of the area wage adjustment is to account for input price variation between different labor markets. The Commission's recommendation accounts for a greater amount of wage variation and therefore represents a technical improvement in the adjustment, regardless of the distributional consequences. If the Secretary believes that the Commission's proposal can be improved upon, we would welcome such improvements. As it stands, however, the Secretary has bypassed an opportunity to correct a fundamental flaw in PPS.

OUTLIER POLICY: The Commission commends the Secretary for attempting, although unsuccessfully, to design and implement needed improvements in outlier payment policy. ProPAC intends to continue work in this area that will complement the Secretary's ongoing analyses of potential improvements to outlier payment policy. The Commission was disappointed that, as an interim measure, the Secretary did not increase the outlier contributions to the maximum allowed under the statute of 6 percent of total projected payments.

CAPITAL PAYMENT POLICY: ProPAC is in basic agreement with the Secretary on the timing and method for bringing capital payments into PPS. We understand, however, that this is likely to be delayed for several years due to Congressional action. If Congress delays the transition to an all-inclusive PPS payment rate, the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities.

RURAL HOSPITALS: The Commission is pleased that the Secretary has expressed concern for the problems of small isolated rural hospitals, a concern that ProPAC shares. The Commission will continue to work in this area and hopes that the Secretary will complete and release relevant studies undertaken some time ago.

RECALIBRATION: Like the Secretary, the Commission believes the DRG weights should be recalibrated annually. An important issue to be resolved is whether recalibration in the future should be accomplished with charge data as the Secretary proposed. The Commission has undertaken a study to examine alternatives using cost data and will share results with the Secretary when they are available.

Technologies, Case Mix, and Coding

In general, the Commission supports the Secretary's intent to further study issues of the DRG classification relating to coding and Grouper logic. The Commission has encouraged the Secretary to evaluate in a more timely manner the need for new ICD-9-CM codes to appropriately identify new diagnoses and/or procedures.

The Commission recognizes that as the DRG classification system evolves, revision of existing logic and assignment criteria may be justified. ProPAC believes, however, that the Secretary's approach has been inconsistent at times. For example, the Secretary groups cochlear implant cases in DRG 49, despite the resulting compromise of clinical coherence within that DRG. This decision indicates that the Secretary does not always regard clinical coherence as a prerequisite for DRG assignment. The Commission believes that changes in policy of this nature should be explicitly discussed.

Finally, the Commission believes that the DRG classification system must be responsive to technological developments and changing medical patterns of practice. We, therefore, have encouraged the Secretary to be more flexible in adopting polices that are adaptable to this changing environment.

Beneficiary and Quality Concerns

The Commission continues to believe that the proportion of inpatient hospital payments borne by beneficiaries should be returned to its pre-PPS level. While the Commission supports the changes enacted by Congress, we believe that it is inappropriate for beneficiaries to pay a higher proportion of inpatient hospital payments after PPS than before. The Commission, therefore, has encouraged the Secretary to examine and propose modifications in policies relating to apparent deficiencies in the cost-sharing structure.

Finally, the Commission believes that the Secretary should initiate a comprehensive evaluation of PRO quality of care review activities and findings. The Commission is pleased with the efforts of the Secretary to evaluate the impact of PRO review on patterns of quality of care. However, these efforts seem tied to the administration of the PRO contracting process. We continue to believe that a substantial, independent assessment of PRO findings and impacts on quality of care is required.

INTRODUCTION

Congress established the Prospective Payment Assessment Commission (ProPAC) at the time the prospective payment system (PPS) was enacted. ProPAC was created to assist both Congress and the Secretary of Health and Human Services (HHS) on the monitoring and updating of PPS. ProPAC submits three annual reports as required by Congress. A report submitted in April to the Secretary of HHS contains the Commission's recommendations on updating Medicare prospective payments and modifying diagnosis-related group (DRG) classification and weighting factors. Beginning in 1988, this report will be submitted in March. A report in June to Congress provides information on a wide range of changes in health care delivery and financing and examines the impact of PPS on the American health care system. A report in November to Congress evaluates the adjustments to PPS made by the Secretary in regulations.

Seventeen Commissioners serve on ProPAC. They are appointed by the Director of the Office of Technology Assessment and serve three year terms. The Commission is assisted by an Executive Director and a staff. The Commission holds scheduled public meetings and invites individuals or groups to attend and participate.

This report provides the Commission's views on the regulatory adjustments made by the Secretary to PPS for fiscal year 1988. The recommendations made to the Secretary in our April 1987 report were considered by the Secretary, as required by the statute. The Secretary's review of ProPAC's recommendations was described in the following Notices of Proposed Rulemaking (NPRMs) and Proposed Notices (PNs):

- Capital Payments under the Inpatient Hospital Prospective Payment System, 52 Fed. Reg. 18840, May 19, 1987, NPRM;
- Changes to the DRG classification System, 52 Fed. Reg 18876, May 19, 1987, PN;
- Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rate, 52 Fed. Reg. 22080, June 10, 1987, NPRM; and
- Recommendation of Update Factors for Rates of Payment for Inpatient Hospital Services, 52. Fed. Reg. 22386, June 11, 1987, PN.

During the public comment period, ProPAC submitted specific comments on the NPRMs and Proposed Notices on July 17, 1987 in separate letters to William Roper, M.D., the Administrator of the Health Care Financing Administration (HCFA) of HHS. On September 1, 1987 final regulations were promulgated by the Department effective for discharges or cost reporting periods occurring on or after October 1, 1987.

This report addresses notices and regulations published September 1, 1987 regarding the updating of the PPS rates, recalibration of DRGs, and changes in technologies, case mix and coding. It also describes other areas of concern in PPS policy that are critical to the optimal functioning of the system.

Public Law 100-119 delayed implementation of the update factors for PPS and PPS-exempt hospitals and incorporation of capital into PPS until November 21, 1987.

Appendixes to this report contain a summary of the final fiscal year 1988 regulatory changes, a comparison of the Commission's April 1987 recommendations and the provisions of the proposed and final regulations, changes in DRG weights between fiscal year 1987 and 1988, and biographical sketches of the Commissioners.

CHANGES FROM FISCAL YEAR 1987 - 1988

UPDATE FACTOR AND PAYMENT AMOUNTS

General Overview

The statute requires the Secretary to update the PPS hospital rates and the excluded hospital and unit rates each fiscal year. Congress, however, overruled the Secretary's update for several years. Moreover, in the Omnibus Budget Reconciliation Act (OBRA) of 1986, Congress required the Secretary to increase the payment rates for PPS hospitals and PPS-exempt hospitals by an update factor equal to the market basket minus two percentage points, for fiscal year 1988. The Secretary was further required to report to Congress on April 1 on what alternative update amounts the Secretary would recommend for FY 1988.

In the Secretary's April Report, he recommended an increase of 1.5 to two percent for fiscal year 1988. The Secretary's final recommendation, however, supports an increase of 0.75 percent for PPS hospitals and an increase of 1.9 percent for PPS-exempt hospitals.

The Commission believes that the 0.75 percent increase recommended for the PPS standardized amounts is too low. Rather, the Commission believes that the 2.3 percent average increase it recommended represents the appropriate update factor for PPS hospitals in fiscal year 1988. Table 1 summarizes the components of the Commission's update factor recommendation and compares it to the Secretary's.

The Commission's update recommendation is stringent. The 2.3 percent recommended update factor for fiscal year 1988 is 2.4 percentage points below the current market basket forecast. Moreover, the Commission's recommended update factors are likely to be stringent at least through fiscal year 1990. The primary reason for this is the Commission's determination that a minus 5.4 percent adjustment be phased in over the next three years to reflect first-year PPS cost information.

In addition, the Commission believes that the 1.9 percent increase for PPS-exempt hospitals and units is too low. While the Commission is pleased that the Secretary recommended a separate and higher update factor for PPS-exempt hospitals and units, we believe an update of 4.2 percent is more appropriate.

The Commission's approach and rationale for its update factor are described below and compared with the Secretary's.

Adjustment to the Standardized Amounts

In past reports, the Commission recommended that when cost data reflecting hospital experience under PPS became available the standardized amounts should be recalculated. Accordingly, ProPAC used first-year PPS Medicare Cost Report data to recalculate the standardized amounts. To do this costs per case from the first-year of PPS were substituted for the 1981 costs per case used to set the current rates. The resulting newly recalculated fiscal year 1987 standardized amounts on average are 12.3 percent lower than the current standardized amounts. This differential is the basis of the Commission's recommendation to adjust the standardized amounts an average of minus 5.4 percent. We believe this adjustment should be phased in over three years. The Commission does not believe that the entire 12.3 percent differential should be adjusted for in the update factor. Productivity gains should be shared between hospitals and the Medicare program. In addition, update factors since the first year have implicitly accounted for part of the differential.

TABLE 1

COMPARISON OF PROPAC AND HCFA/HHS
RECOMMENDED PPS UPDATE FACTORS FOR FISCAL YEAR 1988

	ProPAC	HCFA/HHS
ADJUSTMENT TO LEVEL OF STANDARDIZED AMOUNTS		
Average	**-1.8**[a]	**0**
Urban	-1.9	
Rural	-1.1	
FISCAL YEAR 1988 UPDATE FACTOR		
FY 1988 Market Basket Forecast	**4.7**[b]	**4.7**
Correction for Forecast Error	**0.0**	**-0.4**
Discretionary Adjustment Factor/Composite Policy Target Adjustment Factor	**0.0**[b]	**-3.55**
Scientific and Technological Advancement	0.5	N/S[c]
Productivity	-1.0	N/S[c]
Site Substitution	-0.3	N/S[c]
DRG Case-Mix Index	0.4[b]	0
Within DRG Patient Complexity	0.4[b]	0
OBSERVED CHANGE IN CASE-MIX INDEX (Adjustment Made to DRG Weights After Recalibration)	-0.6[b]	**0**
TOTAL CHANGE IN PPS PRICES (AVERAGE)	2.3	**0.75**
Urban	2.2	0.75
Rural	3.0	0.75

[a] A total adjustment averaging -5.4 percent to be made in three equal increments through fiscal year 1990.

[b] Estimate revised since the Commission's April 1, 1987 Report and Recommendations to the Secretary, based on more recent information included in the HCFA/HHS update factor notice.

[c] Not specified -- included in composite target adjustment factor.

The Commission believes that even though PPS was designed to break the direct link between each hospital's costs and its Medicare payments, payments on average should be considered in relationship to costs. Decisions about the level of PPS prices have partly been based on judgments about the extent to which hospitals could increase productivity and lower their costs. Periodically reviewing more recent cost data is the best way to assess the accuracy of such judgments.

The Secretary's recommended update factor for fiscal year 1988 does not include a similar explicit adjustment to reflect PPS cost information. However, the discussion of the overall recommended 0.75 percent update and the minus 3.55 percent composite policy target adjustment factor suggests that this information was used implicitly in arriving at a recommendation.

The Commission recognizes that the decision regarding how to use the first-year PPS cost information in determining the update relies on judgment, not technical estimates. In developing its recommendation, the Commission considered a number of options regarding the size and phasing of the adjustment. In the judgment of the Commission, however, an update factor as low as 0.75 percent may jeopardize the availability of care to Medicare beneficiaries, particularly in rural areas.

Separate Urban and Rural Update Factors

The recalculated fiscal year 1987 standardized amounts are 13 percent lower than the current standardized amounts for urban hospitals but only 7.6 percent lower for rural hospitals. Therefore, the Commission recommends different adjustments for urban and rural hospitals: minus 5.7 percent the for urban amount and minus 3.3 percent for the rural amount. These adjustments are in the same proportions as the recalculated standardized amount differentials of minus 13 percent and minus 7.6 percent, respectively.

The Secretary rejected this recommendation asserting that separate update factors in conjunction with recent legislative changes would "overcompensate" rural hospitals relative to urban hospitals. In addition, the Secretary maintained that the Commission did not take into account recent legislative changes that reduce the disparity between payments to urban and rural hospitals.

We disagree with these assertions. From Congressional testimony, we understand the Secretary's rejection of separate urban and rural update factors to be based on simulated operating margins. We do not believe that such an analysis is relevant. The intent of recommending separate adjustments was to ensure that the standardized amounts reflect more

recent information about the underlying cost differences between urban and rural hospitals.

If the Commission's recommendation were implemented, the difference between the urban and rural standardized amounts after the third year of separate update factors would be about 14 percent. This percentage is almost identical to the difference in average discharge-weighted urban and rural standardized amounts computed using the first-year PPS cost data.

Finally, contrary to statements included in the notice, recent legislative actions were factored into the analysis. Changes in the relative urban and rural outlier contributions and the teaching adjustment were included in the fiscal year 1987 standardized amounts. The change to discharge-weighted standardized amounts had not yet taken effect. But the end result of the Commission's recommendation, as described above, would be to establish a differential between urban and rural rates consistent with the discharge-weighted differential observed in the first-year PPS cost data. In its deliberations regarding the fiscal year 1989 update factor, the Commission will consider the relationship between urban and rural costs revealed in second- and third-year PPS cost data.

Increase in Per-Case Costs

The Commission is aware that the recently-released Medicare cost report data show a relatively large increase in per-case costs -- in the neighborhood of ten percent -- from the first year to the second year of PPS. Despite this increase in costs per case, we believe that our minus 1.8 percent adjustment to the standardized amount is still appropriate. As described earlier, the adjustment was meant to correct for part of the large discrepancy between actual first-year PPS per-case costs and 1981 per-case costs that were trended forward to set first-year PPS payment rates. The Commission did not adjust for the entire 12 percent differential, believing that efficiency gains should be shared with the hospital industry, and that relatively low update factors in recent years already corrected for part of the differential. The Commission also chose to phase-in the adjustment over three years in order to allow hospitals time to adjust to the new price levels.

None of the judgments affecting the fiscal year 1988 update recommendation are changed by more recent cost data. We will continue to examine second-year and third-year PPS cost data and hope to work with both HCFA and the hospital industry in understanding trends in Medicare hospital costs. These data will be considered in developing our update factor recommendation for fiscal year 1989.

Market Basket and Forecast Error Correction

The Commission believes that the update factor should take into account the most recent market basket forecast available. The Commission's recommended treatment of errors in previous market basket forecasts differs from the Secretary's in several ways, however. The Secretary recommends that all errors in the fiscal year 1986 market basket forecast be corrected in the fiscal year 1988 update factor. The Commission recommended last year that no adjustment be made for fiscal year 1986 forecast error, since the update factor for fiscal year 1986 was not affected by the market basket forecast. In the Commission's judgment, the Congress would have legislated the same 0.5 percent update factor for fiscal year 1986 even if the market basket forecast had been accurate at the time.

The Commission's forecast error correction factor for fiscal year 1988 would take into account errors in the fiscal year 1987 forecasts of external price change measures. (External measures are those not specific to the hospital industry.) Since those errors are estimated to be below 0.25 percent, the Commission does not believe an adjustment is necessary. This position is fully consistent with the recommendations of the Commission in each of its previous April reports.

Policy Target Adjustment Factor/Discretionary Adjustment Factor

In making the update recommendation, the Commission is required to take into account changes in the hospital market basket, hospital productivity, and scientific and technological advances, the quality of care provided in hospitals, and long-term cost-effectiveness in the provision of inpatient services.

The Commission develops numerical estimates for four components of the discretionary adjustment factor (DAF): scientific and technological advances, hospital productivity improvement, site-of-care substitution, and real case-mix change. The Commission believes that it is very important to maintain a consistent methodology for developing the discretionary adjustment factor. In each of its annual recommendations, the Commission has presented the methodology used to develop this factor, together with supporting data. Clearly, without such information, the reasonableness of any recommendation cannot be critically evaluated.

In the recommended update, the Secretary presents a rather general discussion of the philosophy of fiscal constraint as a justification for a policy target adjustment factor (PTAF) of minus 3.55 percent. With the exception of general information on length of stay declines in the first three years of PPS, the Secretary provides no data upon which the

reasonableness of the target might be judged. This represents a departure from previous rules in which the Secretary provided a methodology and data supporting the proposed update factor.

The Commission recognizes that judgment is required in using available information to develop an update recommendation. Nevertheless, we believe that data and a consistent methodology should be the foundation of such judgments. Therefore, the Commission is disappointed that the Secretary did not apply the methodological approach used in the past to develop the PTAF. We doubt that this methodology would lead to a judgment that minus 3.55 percent is the appropriate policy target adjustment factor. In any case, without supporting information, the Secretary's PTAF appears to represent an unreasonable reduction in hospital payments.

Case-Mix Change

The Commission is relieved by the Secretary's report that case-mix change is leveling off and that this phenomenon, which has been particularly troublesome in previous debates over the update factor, is diminishing in importance. The Secretary's treatment of no adjustment for case-mix change is consistent with the Commission's April recommendation which was based on estimates of offsetting real case-mix change and upcoding.

The Commission believes that case-mix change information should be systematically used in setting the PPS update. Accordingly, we modified our recommendation in response to information provided by the Secretary in the update notice. These changes were reflected in our comment on the Secretary's recommended update.

The Commission believes that the phenomenon of case-mix change bears careful watching in the future. Additional changes in medical record coding practices are entirely possible in response to changes in DRG classification and weights. For example, changes in age as a criterion for defining DRGs, changes in the surgical hierarchies, and restructuring the alcohol and drug abuse DRGs may affect coding practices in amounts that are currently unpredictable. Therefore, continued monitoring of DRG frequencies and weights is necessary.

The Commission also believes that it is necessary to continue to monitor real case-mix change, both across and within DRGs. Last year, based on data and analysis furnished by the Commission on Professional and Hospital Activities, we included a component in our update recommendation for within DRG case complexity change. This year we reduced this component because we believe that stabilizing admission

rates, lengths of stay, and across-DRG case-mix change should be associated with a decline in within-DRG case complexity change.

Our estimates in this area are admittedly imprecise, and we hope to be able to refine them in the future. Similarly, we believe it is necessary to refine existing methods of partitioning observed changes in case-mix indexes into real change and upcoding components. We are, therefore, pleased that the Secretary has agreed to assess the feasibility of a record abstraction study for this purpose and has invited ProPAC to participate in the study.

Update Factor for Excluded Hospitals

The PPS statute created two broad class of hospitals -- those paid on the basis of DRGs and those that are not. Excluded hospitals - psychiatric, rehabilitation, pediatric and long-term care - continue under cost reimbursement rules, subject to limits. The types of patients and the treatments they receive vary significantly between PPS hospitals and excluded hospitals. The Commission has argued that these hospitals should receive a separate update. In OBRA 1986, Congress provided the Secretary with clear authority to establish target rates of increase for excluded hospitals separate from the PPS update factor.

We are gratified that the Secretary has accepted the Commission's advice and is recommending to the Congress a separate and higher update factor for excluded hospitals and units. Nevertheless, we are concerned that an update factor of 1.9 percent for these hospitals is too low.

The Commission's update factor recommendation for excluded hospitals and units includes two allowances in addition to inflation -- one for scientific advancement, and another is for productivity change. The Commission recommended a total 4.2 percent update factor for these hospitals.

We are unable to evaluate the merits of the Secretary's arguments for a 1.9 percent update in the absence of any supporting data or consistent methodologies. Nor are we able to evaluate the adequacy or inadequacy of the various PTAF adjustments as they might relate to the adjustments made for PPS-exempt hospitals and units.

Improving the Definition of Hospital Labor Market Areas

The Commission strongly disagrees with the Secretary's response to its recommendation for improving the definition of hospital labor market areas.

The Commission recommended in its April 1987 report that the definitions of urban hospital labor market areas should be improved by distinguishing between central and outlying areas. The rural hospital labor market areas should be improved by distinguishing between urbanized rural areas and other rural areas. The Secretary rejected this recommendation citing a need for additional study and analysis. The Commission strongly disagrees with the rationale for the Secretary's response.

The Secretary states that additional study and analysis are necessary to evaluate the options and to determine their impact. The Commission, meanwhile, has had a long-term commitment to this issue and has studied it extensively. The Commission has made recommendations calling for improvements in labor market area definitions in each of its annual reports to the Secretary since April 1985. Furthermore, ProPAC conducted its own major study which led to specific recommendations for improvements in the 1987 report to the Secretary.

Last year, Congress enacted legislation requiring HCFA to report on methods for improving hospital labor market areas by May 1987. This legislation also required HCFA to collaborate with ProPAC on this report. The results of ProPAC's study have been shared with HCFA staff. HCFA, on the other hand, has not been as forthcoming with the results of its study. In view of the Secretary's response, the Commission is disappointed by the limited extent of HCFA's collaboration with us on this issue. The Commission's study produced information necessary to evaluate the impact of its recommendation upon hospital payments. We are very willing to collaborate with HCFA on further impact analysis. We disagree, however, with the Secretary's reasons for wanting to delay implementation of labor market improvements.

The Secretary claims that "any analysis of redefined labor markets must be considered in the context of the payment effects to hospitals. It is not sufficient to define an improved wage index merely in terms of that index's ability to explain a greater amount of variation in hospital (labor) costs." We believe that this statement is completely contrary to the purpose of the area wage index and labor market areas.

The area wage adjustment is supposed to account for input price variation between different labor markets. ProPAC's recommendation accounts for a greater amount of wage variation between labor markets, and therefore it represents a significant technical improvement in the area wage adjustment. The Secretary has supported technical improvements in the past that were intended to preserve the integrity of the payment system. We believe that refinements in the definition of labor market areas should not be accepted or rejected solely on the basis of their redistributive effects, as the Secretary seems to be suggesting.

The Secretary is concerned that our recommendation will substantially increase the number of labor market areas with fewer than three hospitals. According to the Secretary, this will result in a virtual pass-through of labor costs for hospitals in these areas. ProPAC's recommendation would increase the percentage of urban labor markets with fewer than three hospitals from about 21 percent to 39 percent. However, we disagree with the Secretary's position for several reasons.

First, hospitals do not receive additional payments that are directly related to increases in their wages. Additional payments for higher wages can only be obtained through updates in the area wage index. Except in areas that have only one hospital, hospitals cannot be certain of the impact of their wage increases upon future values of their area wage index. Second, there is usually a lag of several years between updates of the wage index. Even if hospitals in small areas could raise their wages in an unrestrained manner, they would have to wait several years for their higher wages to be reflected in a higher wage index. Third, Medicare revenues represent, on average, about 40 percent of hospital revenues. This provides a restraint on hospital wage growth, because hospitals cannot be certain of receiving higher payments from other payers for their higher labor costs. The Commission also believes that hospitals face market forces that restrain their wage growth even in small areas. For these reasons, the Commission believes that hospitals in small areas will not receive a virtual pass-through of wages.

The Secretary claims that our recommendation for using urbanized areas will produce boundaries that do not reflect current market boundaries. This is presumably because urbanized area boundaries are based on population density, which is constantly changing, and are redefined only once every ten years by the Census Bureau. The Commission believes that there are very few hospitals that would be affected by this lag in updating the urbanized area boundaries. Furthermore, this claim does not change the fact that hospitals in urbanized areas have substantially higher wages than hospitals in surrounding suburban areas. The Secretary also states that it is not possible to determine whether hospitals are located in urbanized or nonurbanized areas. The Census Bureau has assured us that it is possible to make such a determination.

In rural areas, the Secretary states that many of the hospitals in urbanized rural areas are rural referral centers. He also states that changes in payment policies for these hospitals will reduce the need for refining the definition of rural labor market areas. Although many rural referral centers are located in urbanized rural areas, most of the hospitals in these areas are not HCFA-designated rural referral centers. Changes in payment policies for rural referral centers, therefore, do not

address the fact that hospitals in urbanized rural areas have higher wages than hospitals in other rural areas.

Improving the Area Wage Index

The Commission recommended that the Secretary update the hospital wage data necessary for calculating the area wage index on a regular basis. This updated information should include data on the wages and hours of employment for hospital occupational categories.

The Commission is pleased with the Secretary's intention to update the wage index on a regular basis and to collect wage data according to occupational categories. During the upcoming year, ProPAC also intends to further examine the feasibility of collecting hospital wage data on a regular basis.

The Commission also supports the Secretary's proposal to modify the methodology for computing the area wage index. We agree that changing the computation of the national average hourly wage from area-weighting to hour-weighting will reduce the administrative burden of continually revising all the area wage index values. We also agree that this change, by itself, will not affect the distribution of hospital payments.

The Commission has not had an opportunity to evaluate the impact of blending 1984 wage data and 1982 data. In principle we support the Secretary's proposal to implement a blended wage index based on 1982 and 1984 data to reduce the impact of large changes in the index values of some areas. We believe, however, that a blended rate should not be used for a period of more than one year.

RURAL HOSPITAL ISSUES

General Overview

The Commission is pleased to see growing interest in the problems rural hospitals face under PPS. New data supports this growing interest. We believe there is now enough information to begin reexamination of PPS payment policies for rural hospitals. The Commission is currently conducting several studies which will assist in this evaluation. In addition to our ongoing studies of the area wage index, the Commission's planned studies include evaluations of the appropriateness of maintaining separate urban and rural payment rates, and the adequacy of current PPS payment policies for protecting isolated rural hospitals.

While we believe that reexamination of these payment policies is essential, the necessary studies will take some time to complete. Meanwhile, modifications can be made to address obvious inequities. The Commission recommended some of these modifications in its April report to the Secretary. The following discussion outlines these recommendations and the Secretary's response.

Extension of Volume Protection to all Isolated Rural Hospitals

The Commission recommended that the Secretary seek legislation to expand the eligibility for a prospective payment volume adjustment to all isolated rural hospitals that meet the criteria for sole community hospital status.

We are pleased that the Secretary is evaluating legislative alternatives to address the needs of small isolated rural hospitals. The Secretary questions, however, whether a satisfactory solution can be achieved by simply expanding the volume adjustment to all isolated rural hospitals that meet the criteria for sole community hospital status, irrespective of whether their PPS payment rates are calculated on fully national or blended national/hospital specific rates.

The Commission did not intend that this recommendation would be a panacea to the problems of isolated rural hospitals. In fact, we continue to be concerned that the sole community hospital provisions may provide inadequate financial protection for these hospitals. We are pursuing a number of activities including study of whether a per-case payment system is appropriate for small isolated rural hospitals.

Nevertheless, the Commission believes that expansion of the volume adjustment provision is required to ensure equity among providers that qualify for sole community hospital status. If the intent of this provision is to protect sole community-type hospitals from financial risk due to volume declines outside of their control, then it should be extended to all hospitals that might be so classified under the appropriate criteria.

Clarification of Sole Community Hospital Volume Criteria

The Commission recommended that the Secretary issue implementing instructions to clarify the criteria used to grant the sole community hospital volume adjustment. The Commission further recommended that the application procedure for an adjustment be simplified.

The Commission is pleased to learn that implementing instructions have been drafted. We are also pleased by the regulation's revision of the "extraordinary circumstances" criterion. Formerly, an adjustment would

be granted only if volume declines were due to "extraordinary circumstances beyond the hospital's control." The revised criterion grants an adjustment if volume declines are due to "circumstances beyond the hospital's control." We agree that the former criterion was unnecessarily restrictive and inconsistent with the statute.

However, it is critical that implementing instructions be issued as soon as possible to clarify the exact circumstances under which an exception would be granted. Without such instructions, confusion will continue. In addition, the Commission is concerned about the Secretary's use of profits as a criterion for denying an adjustment for volume declines. We believe that this policy should be carefully evaluated to determine its impact on sole community hospitals.

Evaluation of Current PPS Policies for Rural Hospitals

The Commission recommended that the Secretary complete the studies mandated by Congress and make them publicly available as soon as possible. In the preliminary notice to the regulation, the Secretary stated that three of the Congressionally mandated reports on rural hospital issues were being prepared. The final rule was silent on this issue. Nevertheless, we have been awaiting release of these reports since the end of last year, the time the Secretary had announced they would be ready for distribution.

We understand that issuance of the reports requires a sometimes lengthy clearance process, but hope that this process can be expedited. The results of the Secretary's studies may prove to be very useful in focusing current public debate on a subset of rural hospital policies most in need of correction.

CAPITAL PAYMENT

The Commission is pleased that the changes devised by the Secretary generally are consistent with our recommendations regarding the incorporation of capital-related costs under PPS. The Commission and the Secretary are in agreement that continued retrospective cost-based reimbursement for capital introduces distorted incentives for capital investment decision making. After several years of careful consideration and analysis, both the Commission and the Secretary have determined that capital costs, like operating costs, should be paid on a prospective basis.

Pub. L. 100-119 delayed implementation of this regulation until November 21, 1987. It appears that Congress may extend the cost-pass through for an additional period of time.

The incorporation of capital costs into the prospective payment system would have begun on October 1, 1987. Fixed capital expenditures would be phased in over a period of 11 years, heavily-weighted toward the hospital-specific portion in the early years. Moveable capital would be phased in over an eight-year period, also heavily-weighted toward hospital-specific payments in the early years. Hospital-specific payments would be based on each hospital's actual allowable capital-related costs for fixed and moveable capital in each year of the transition. The hospital-specific capital payments would be subject to seven and ten percent reductions, for fiscal years 1988 and 1989, respectively, as specified in The Omnibus Budget Reconciliation Act of 1986 (OBRA).

The federal rates would be based on national capital-related costs for cost reporting periods beginning in federal fiscal year 1984. These costs would be updated to fiscal year 1987 by an estimate of the actual rate of increase in inpatient capital costs. The rates for 1988 and 1989 would be updated by the actual rate of increase, subject to budget neutrality adjustments. For fiscal years 1990 and beyond, the rates would be updated by the PPS update factor. The federal rates would be standardized for case-mix complexity, indirect teaching, and disproportionate share adjustments. They would be reduced further by an appropriate amount to account for outlier payments. The federal payment rates for fixed capital would be adjusted by a construction cost index. The Secretary would reduce the standardized amounts by an additional five percent to allow for additional payments to hospitals with high capital-related costs.

The Secretary's prospective payment method is similar to that proposed by the Commission. The method for establishing the total level of capital payments is consistent. Further, the OBRA spending reductions would be taken equally from the hospital-specific and federal portions, as the Commission recommended. The major differences between the methods concerns the transition from hospital-specific to fully prospective rates. The Commission recommended a ten-year straight-line transition for fixed and a three-year straight-line transition for moveable. The Secretary's transition periods are longer, particularly for moveable, and the payments are heavily-weighted to hospital-specific in the early years of each transition.

While the Commission continues to endorse prospective payment for capital, it recommends careful monitoring of its implementation. As with any major change to the Medicare payment system, incorporating capital under PPS is likely to redistribute payments among hospitals. Thus the Commission recommends continual monitoring of the new payment method with particular attention to redistributive effects. We understand,

however, that Congress is likely to delay the transition to an all-inclusive PPS rate. If this occurs, the Commission, believes that the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities.

TIMELY AVAILABILITY OF COST DATA

The Commission has previously identified the need for more timely hospital cost report data for improving PPS and for assessing the effects of PPS on hospitals. In its 1986 report, the Commission encouraged the Secretary to consider alternative strategies for sampling cost report data. In addition, the Commission stated its intention to study the feasibility of developing a representative sample of PPS hospitals. This study was undertaken in preparation for our 1987 report.

There is a considerable lag in obtaining a complete set of cost reports. The lag results in part because most hospitals' accounting years begin after the start of the Federal fiscal year. As a result, it takes up to 15 months after the end of the federal fiscal year to receive a complete set of cost reports. Additional time is needed for audits and entering the data into the automated processing system.

The Commission conducted a study of whether cost data received early in the fiscal year (an "early return") can be used to estimate the cost characteristics of PPS hospitals as a whole. This study shows that empirical weights can be developed for the sample to produce precise and representative cost estimates for PPS hospitals. Therefore, the Commission recommended that Medicare Cost Report data be collected routinely from a sample of PPS hospitals. The sample should include hospitals with accounting years beginning in the first four months of the Federal fiscal year. The Commission intends to complete further study on how an early return sample could be developed for hospitals and units excluded from PPS.

The Commission is pleased that the Secretary concurred with ProPAC's recommendation. We also note that the Secretary has made significant improvements in availability of cost data for the third-year of PPS. Sampling cost reports from the first part of the fiscal year is an important step towards speeding the availability of cost report data. Further, ProPAC welcomes the opportunity to work with the Secretary's staff to review the cost reporting process and identify other factors that may contribute to the current lag in the availability of data.

PAYMENT FOR OUTLIER CASES

The Commission stated in its April 1987 report that current outlier payments may not adequately protect hospitals from the risk of extremely costly cases. The Commission supports the intent of the Secretary's originally proposed changes in outlier policy. We agree that a higher fraction of outlier payments ought to be for extremely costly cases rather than for cases with extremely long stays. We are pleased, however, that the Secretary chose to postpone implementation of this policy. The Commission believes that the proposed changes would not have fulfilled their intent and would have had a long-term adverse effect on hospital pricing policy.

Under the Secretary's proposal, the majority of outlier cases would become cost outliers. The Commission believes that applying a national cost to charge ratio to approximate individual hospitals' costs is unwise. This plan would inappropriately reward hospitals with high charges relative to costs. It would also give hospitals an undesirable incentive to raise their charges. We would much prefer the use of hospital-specific cost to charge ratios to approximate individual hospitals' costs. The Commission is encouraged that the Secretary is researching the impact of using national ratios in computing cost outlier payments.

The Commission believes that outlier policy needs to be modified and encouraged HCFA to complete the necessary analyses in a timely manner so that refinements to outlier policy could be implemented for the 1988 payment year. The Commission is disappointed that HCFA was unable to make the changes necessary to implement outlier payment improvements for fiscal year 1988. We would be pleased to work with the Secretary in this effort.

In addition, the Commission believes that current outlier contributions are too low. The Commission is evaluating alternatives regarding an appropriate set-aside that would balance the risk-reduction objective of outlier payments with the cost-reduction incentives of fixed price payments. The Commission would be happy to work with the Secretary to determine the appropriate set-aside amount for future outlier payment policy reform. The Commission also restates it longstanding concern regarding quality of care and access to care. No outlier policy decisions should adversely affect the ability of Medicare beneficiaries to receive appropriate care.

The Secretary indicated the changes in the outlier pool will be studied along with other possible refinements. As an interim measure, the Commission recommended that outlier contributions should be increased to the maximum allowed under the statute of 6 percent of total projected

payments. We regret the Secretary did not make this change. The Secretary should also take the necessary steps to ensure that outlier payments closely approximate the amount set-aside for outliers.

The Commission is conducting analyses to assess the effectiveness of current outlier payment policy as well as several possible modifications. One alternative emphasizes cost outliers. Results will indicate the effect of current and alternative outlier policy on reducing hospital financial risk. Analysis should also examine the impact of outlier payments on specific types of hospitals. The Commission will share the results of these analyses with the Secretary as they become available.

RECALIBRATION

ProPAC recommended annual recalibration in its April 1986 Report. OBRA 1986 included a provision requiring annual change. Thus, the Secretary will recalibrate the DRG weights annually, beginning in fiscal year 1988.

The Secretary states the importance of choosing a data base that reflects current relative resource use when recalibrating DRG weights. An earlier analysis by the Secretary, replicated by ProPAC, found that weights based on charge data had a high degree of correlation with weights based on cost data. As a result, DRG weights for fiscal year 1988 are recalibrated using charge data for Medicare discharges for fiscal year 1986.

The Commission agrees that the choice of a data base is critical to annual recalibration of the DRG weights. The weights should be based on data that most accurately reflect the relative resources used to treat patients in the various DRGs. The initial weights were based on charges adjusted for costs using Medicare Cost Report data. For fiscal year 1986, however, the Commission supported the Secretary's recalibration using only charge data from the PATBILL file.

ProPAC supported that use of charge data for two reasons. First, we conducted an analysis, similar to HCFA's, that showed a very strong correlation between weights based on charges alone and weights based on charges adjusted for costs. Second, at that time cost data reflecting PPS experience were not yet available. Therefore, adjusting the patient-level charge data to reflect pre-PPS per-diem costs and cost-to-charge ratios did not seem warranted.

The Commission believes, however, that the decision to recalibrate the DRG weights using charge data alone should be based on updated analysis. This is particularly true because more recent cost data are now available. Although the earlier analyses showed that the overall correlation between

the charge-based and cost-based weights is very high, for some DRGs the weights were substantially different. Moreover, changes in the pattern of cost-to-charge ratios across hospital departments may have occurred in recent years as a result of PPS incentives or other changes taking place in the hospital industry.

The Commission intends to conduct an analysis comparing charge-based and cost-based weights using fiscal year 1986 patient level data and cost data from the second year of PPS. We will share the results of the analysis with HCFA when they become available.

TECHNOLOGIES, CASE-MIX, AND CODING

General Overview

The classification of cases into DRGs is complex. First, the physician enters into the patient's record the principal diagnosis, additional diagnoses, and procedures performed during the inpatient stay. The patient information is then translated into ICD-9-CM codes. This information is transmitted to the hospital's fiscal intermediary (FI) on the hospital's request for payment. The FI then enters this information into its claims system and subjects it to a series of automated screens collectively called the Medicare Code Editor (MCE). After screening through the MCE, each case is classified by the Grouper software program into the appropriate DRG.

The Grouper program was developed as a means of classifying each case into a DRG on the basis of diagnosis, procedures codes, and demographic, information. In addition to its use in determining payments it also measures relative hospital resource consumption to establish DRG weights.

The Secretary implemented numerous changes for fiscal year 1988 in the DRG classification system to resolve some of the problems identified by analyses and comments. The Secretary also stated his intent to continue examination of coding and payment issues. ProPAC supports this intention.

The Commission has previously addressed in detail issues relating to ICD-9-CM including: 1) the need to maintain and update the ICD-9-CM coding system in a timely and effective manner; 2) the interpretation and assignment process for existing ICD-9-CM codes; and 3) the establishment of an interim mechanism to allow early identification of new technologies, procedures, and diagnoses when timely updating of the

coding system is not possible. Several recommendations regarding ICD-9-CM coding were included in the April 1987 report to the Secretary.

For example, the Commission has previously discussed the need for specific and unique codes to identify new conditions or treatments. Currently the ICD-9-CM Coordination and Maintenance Committee meets only quarterly. As a result, there are extreme time lags between identification of needed revisions to ICD-9-CM and implementation of coding changes. For instance, effective October 1, 1987, the Secretary implemented new ICD-9-CM procedures codes to describe pacemaker procedures. While the change is consistent with a similar ProPAC recommendation made almost two years ago, the Commission is concerned about the inordinate delay in making the changes. Delays like these hamper data collection, analysis, and prompt appropriate payment for changed medical technology and treatment practices.

While the Commission generally supports the changes in DRG classification, we are concerned about the absence of a systematic approach to altering the basic tenets of the DRG assignment logic. The Commission recognizes that the original DRG system was based upon a set of rules that govern assignment of cases to specific DRGs. When the DRG system was initially implemented, clearly formalized logic such as the distinction between types of procedures (e.g. OR and non-OR) was established. Over time, revisions to the system have resulted in changes to this initial assignment logic. For example, the Secretary's changes for mechanical ventilation patients uses non-OR procedures to group cases. In addition, this revision results in an intermingling of medical and surgical cases within one DRG.

The Commission recognizes that as the system evolves, revision of existing logic and assignment criteria to assure more appropriate grouping of cases and equitable payment may be justified. However, the Commission believes that these modifications should be formally established and explicitly described. For example, the Secretary groups cochlear implant cases in DRG 49, despite the resulting compromise of clinical coherence within that DRG. This decision indicates that the Department does not always regard clinical coherence as a requirement for DRG assignment. This change in policy should be explicitly discussed.

The Commission also supports the Secretary's efforts to use combinations of codes to appropriately describe a given condition or treatment. A good example is the use of both 93.92 and 96.04 to describe cases involving mechanical ventilation through intubation. Another example of potential coding problems results from the use of not otherwise specified (NOS) codes as complications or complex diagnoses. While we generally support the addition of NOS codes as a CC to DRG 124, we believe that

the use of NOS encourages vague and inaccurate documentation and coding.

The Commission believes that the Secretary should clearly articulate his guidelines and ensure that they are used consistently throughout the DRG system.

Finally, the Commission is concerned that in some instances there may have been insufficient analysis done to examine the financial impact of proposed changes. Do the new groupings result in cases which are similar in resource use? We believe that such analysis is necessary to determine the extent of financial impact and its importance.

Decisions Affecting a Particular MDC

It is not clear to the Commission why the Secretary refuses to adopt technology-specific DRGs, as an interim measure, for assigning cases involving new technologies. We believe this approach would assure payments that more accurately reflect the costs of these cases and minimize adverse incentives to a new technology's adoption and use. Payments and weights should be based on the best available cost data, and not necessarily limited to Medicare experience.

Cochlear Implants. -- The cochlear implant is a prosthetic device that can increase the hearing ability of certain profoundly deaf individuals. Currently, discharges involving the implantation of this device are assigned to DRG 49 (major head and neck procedure). The Commission believes that the classification of cochlear implant cases into DRG 49 is inappropriate in terms of both resource consumption and clinical coherence. Therefore, the Commission recommended that cochlear implant cases be assigned to a new, temporary, device-specific DRG.

The Secretary rejected ProPAC's recommendation. The Secretary did, however, implement three unique ICD-9-CM codes for cochlear implant cases to allow for the tracking of such procedures.

The Secretary agrees with the Commission that cochlear implant cases are not clinically coherent with other cases in DRG 49. DRG 49 contains many cases with long lengths of stay and labor-intensive procedures. Cochlear implant cases, however, require a very short length of stay and do not involve labor-intensive procedures.

In terms of resource consumption, the Secretary states that early fiscal year 1987 PATBILL data show less than a five percent difference in average standardized charges between cochlear implant cases and the other cases in DRG 49. The analysis did not mention how many of the

cases were single-channel and how many were multi-channel devices. Researchers estimate that approximately 90 percent of patients will be receiving multi-channel cochlear implants. ProPAC's analysis of hospital cost data showed multi-channel cases have average costs of approximately $14,250 and that the average payment for DRG 49 is $10,000. The payment hospitals receive under DRG 49 will not reflect the costs of implanting the multi-channel device. Therefore, we believe that payment will be inadequate for the majority of cochlear implant cases.

The Commission believes that the cochlear implant is an important, new, and developing technology. There are no existing DRGs which are appropriate for this technology. Therefore, a technology-specific DRG is a valuable alternative for unusual circumstances such as this one. We recognize the limitations of the available data which the Secretary used to assign cochlear implants to DRG 49. However, ProPAC believes that it would more meaningful, in terms of resource use and clinical coherence, to assign cochlear implant cases to a temporary device-specific DRG. The initial weight could be estimated using the best available data, including non-Medicare data. The DRG weight could then be reassessed after one or more years based on Medicare experience. Basing payments on one year of non-Medicare data seems preferable to assigning cochlear implant cases to DRG 49.

Implantable Defibrillators. -- The implantable defibrillator is a relatively new medical device used in the treatment of some life-threatening ventricular arrhythmias. Currently, implantable defibrillator cases are assigned to DRG 104 (cardiac valve procedures, with pump and with cardiac catheterization). However, the resource needs of cases involving implantable defibrillators differ from other cases in DRG 104. Therefore, the Commission recommended that implantable defibrillators be assigned to a new, temporary, device-specific DRG. This assignment would result in a weight that more accurately reflects the actual costs of using the device. It would also create more neutral financial incentives for the diffusion and use of this device.

The Secretary did not concur with this recommendation. However, the Secretary implemented other improvements in the classification of these patients.

The Commission agrees with the need to improve the classification of patients with implantable defibrillators. We agree with plans to assign replacement cases to DRG 120. Both PATBILL and manufacturer data indicate that replacement cases are currently underpaid under DRG 117. Thus, the substantially higher weight for DRG 120 more accurately reflects the costs of these cases.

We also agree with the attempt to separate payments for cases with and without electrophysiologic testing, since data indicate that there are substantial differences in costs. It appears that careful monitoring of these cases will be warranted, however, and we urge the timely adoption of ICD-9-CM codes for electrophysiological testing. If payments are considerably greater relative to costs for cases in DRG 105 (that is, cases not involving electrophysiological testing) compared to DRG 104 cases, then a strong incentive to unbundle defibrillator implantation from electrophysiological testing could be created.

The cochlear implant and the implantable defibrillator both illustrate the problems associated with long delays in assigning ICD-9-CM codes to new technologies and procedures and obtaining Medicare program data. These delays prevent adequate evaluation of the appropriateness of DRG assignment. Again the Commission urges the Secretary to consider temporary, device-specific DRGs using the best available data to set a weight during the early phase of a new technology.

Mechanical Ventilation Patients. -- The Secretary received several comments that payments under the DRG classification system have failed to recognize the higher costs of patients receiving mechanical ventilation. Therefore, the Secretary created two new DRGs to recognize the higher costs associated with mechanical ventilation of patients who have a principal diagnosis of diseases and disorders of the respiratory system.

The Commission generally supports the Secretary's efforts to improve the classification of ventilator patients within MDC 4. It is appropriate to increase the reimbursement for these patients to reflect their very high resource use and costs. However, the Commission is concerned that incentives exist in the proposed new DRGs that may inadvertently promote the inappropriate use of tracheostomies and ventilator care.

The Secretary should continue to seek alternative means of classifying these high cost patients based on diagnostic rather than procedural information. For instance, the use of respiratory failure codes may result in a better classification of patients. The Commission concurs with the Secretary that close monitoring of practice patterns under these new DRGs should be undertaken by HCFA and the PROs.

Finally, the Commission believes significant payment inequities exist for ventilator patients outside MDC 4 and therefore supports the Secretary's further investigation of this topic.

The newly created ICD-9-CM code (518.81) for respiratory failure will be useful for further analysis of the incidence and distribution of such patients across DRGs.

Additional Payment for MRI. -- In its 1986 report, the Commission recommended that for a three year period Medicare should pay hospitals an additional amount, or add-on, to reflect the operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital. The Secretary rejected this recommendation. The Commission continues to believe that an alternative mechanism is necessary to reflect the operating costs for MRI scans.

The Secretary again rejected this recommendation suggesting that ProPAC's concern is anticipatory. The Secretary, however, implemented ICD-9-CM codes for MRI scans. We are pleased at the adoption of these codes which will permit a more thorough evaluation of the use of this technology.

The Commission is disappointed that the Secretary again rejected our recommendation for an add-on payment for MRI scans performed on Medicare inpatients. We continue to believe that a special payment mechanism is needed to assure MRI's appropriate adoption because it is such an important new diagnostic technology. We continue to be concerned that insufficient DRG payments could adversely affect quality of care.

Changes Affecting Multiple MDCs

Elimination of Age Over 69. -- Patient age was used to define 190 DRGs that distinguish patients who are under 70 from those who are 70 or older. Patient age is typically used in combination with the presence or absence of a complication or comorbidity (CC). ProPAC analyzed charges from the 1984 PATBILL file to determine the relative effects of the presence of a CC and beneficiary age 70 years or more. The study found that the presence of CC is the critical factor. In almost all cases, the Commission found that defining DRGs based only on the presence of CC is appropriate in grouping Medicare cases for payment purposes under PPS. Therefore, the Commission recommended that DRGs should not be defined on the variable of age greater than 69 and/or presence of a CC.

The Commission is pleased that the Secretary accepted our recommendation to eliminate "age greater than 69" as a criterion for DRG classification. As indicated in the notice, ProPAC analyses have demonstrated that the current criterion, using age in conjunction with the presence of a CC is inappropriate. Thus, the Commission supports the Secretary's change.

In its April 1987 report, the Commission also urged the Secretary to study other DRGs that currently do not split on age and CC. Some of

these DRGs may now need to be split using the CC only criterion. The Commission again encourages the Secretary to examine this area of potential improvement in DRG classification.

Refinements of Complications and Comorbidities Listing.-- In both the April 1985 and 1986 reports the Commission stated its intention to continue studying classification problems for specific DRGs and groups of DRGs. ProPAC completed several of these analyses. One area identified for further examination was the list of complications and comorbidities. ProPAC study also evaluated the cumulative effect of multiple CCs.

Based on these studies, the Commission recommended that the Secretary revise the current list of CCs, and its use in defining DRGs, to ensure more appropriate grouping of Medicare cases for payment purposes. In addition, the Secretary should evaluate several possible approaches to aggregate multiple CCs to better account for variations in resource groups.

The Secretary modified the DRG Grouper logic so that certain diagnoses generally included on the list of CCs would not be considered a valid CC in combination with a particular diagnosis. ProPAC believes these types of changes have the potential to improve the use of CCs within the DRG system, as suggested in our recommendation. The Commission supports the Secretary's refinement of the list of CCs to help assure more accurate identification of CCs and to ensure more appropriate grouping of cases for payment purposes under PPS. The Commission believes that an empirical analysis of these changes should be conducted to substantiate the need for such revisions.

The Secretary indicates that the changes to the CC list generally are based on ICD-9-CM coding rules. However, this is not always apparent from the notice. The Secretary should clearly distinguish between coding rules required for hospital reporting purposes and the application of such rules by the Grouper logic for payment purposes.

Updating the Surgical Hierarchies and the List of Operating Room Procedures. -- The DRG system uses operating room (OR) procedures for grouping patients. Operating room procedures within each major diagnostic category (MDC) are assigned to a surgical hierarchy. This hierarchy reflects the intensity of resource use for each OR procedure as determined by clinical judgement. A patient with multiple procedures is assigned to a surgical DRG based on the most resource intensive OR procedure in that hierarchy.

The Commission recommended that the Secretary evaluate the surgical hierarchies periodically. They should be updated to determine both the

clinical appropriateness and resource intensity of the procedures within each class and the relative order of the modified surgical classes.

The Commission is pleased that the Secretary supports our recommendation to review and revise the surgical hierarchies on an annual basis. The Secretary's changes are primarily limited to a reordering of the current procedure groups based on the most recently available data. We wish to reiterate our belief that the surgical procedures within each procedure group should also be evaluated on a regular basis. The Secretary's response did not directly address this part of our recommendation. Nevertheless, we believe that it is equally important to revise the current procedure groups, as was done for certain non-OR procedures, so that they are more reflective of current technology and costs.

In addition, the Secretary's response does not accurately represent the Commission's position concerning the use of clinical expertise. In the discussion language supporting our recommendation, we stated that clinical expertise should be combined with empirical analysis, using the most recent data on the resource intensity of procedures, to produce revised procedure groups. The Commission did not recommend that clinicians should determine the order of revised procedure groups as indicated by the Secretary.

Proposed Changes to Reduce Inappropriate DRG 468 Assignment

DRG 468, unrelated OR procedures, is reserved specifically for those cases in which none of the surgical procedures furnished to a patient is related to the principal diagnosis. It was established as a means of identifying cases that can not be readily grouped with other clinically similar patients. The reason is that these cases have atypical treatment patterns. The Secretary noted several problems leading to an inappropriate DRG 468 assignment. For instance, there are situations when a minor superficial skin procedure, such as wart removal, is performed on an inpatient with an unrelated diagnosis. This would result in the case being assigned, inappropriately, to DRG 468.

The Secretary, therefore, implemented changes to reduce inappropriate DRG 468 assignment. The Commission is pleased with these changes. The Commission believes, however, that a comprehensive evaluation of patient assignment in DRG 468 should be conducted. This evaluation is necessary because DRG 468 continues to have a high volume of cases. Furthermore, despite the changes, we believe that DRG 468 will continue to be very heterogeneous both clinically and with respect to resource use.

Coding Issues

ICD-9-CM Coding and Grouper Logic. -- The notice included several comments regarding the use of the ICD-9-CM coding system within the DRG classification system.

The Secretary states that several changes discussed in the Grouper notice address the Commission's recommendation regarding Improving Grouper Logic and Coding. However, the changes do not explicitly address the Commission's concerns regarding Chapter 16 of the ICD-9-CM coding system. While the Secretary states that the ICD-9-CM Coordination and Maintenance Committee should address the Commission's concerns, the Secretary does not specify how or when this might occur.

Further, the Secretary stresses that refinement to coding guidelines is dependent on consensus within the user community and among coding experts. The Commission encourages the Secretary to solicit expert coding advice regarding the changes and then expeditiously implement changes, with or without consensus. As we previously noted, this process should be accelerated to prevent inordinate delays.

Removal of Certain Codes from the Surgical List. -- Because new codes were approved before final changes for fiscal year 1987 were made, the Secretary accommodated the codes into the system without classification changes. That is, for purposes of assigning a case to a DRG, the new code was treated the same way as the code previously used to identify the procedure or diagnosis. This resulted in some inappropriate DRG classifications in that several new procedure codes were placed on the OR list despite the fact that they usually did not involve an operating room. Therefore, the Secretary, based on the advice of medical consultants, removed certain codes from the surgical list.

The Commission generally supports the rationale for the Secretary's proposal to eliminate certain non-OR procedures from the OR list. We believe a review of the OR list for potential revision should occur regularly. However, based on the information provided by the Secretary, we are unable to determine whether the change in DRG assignment for cases with these procedure codes is appropriate in terms of both clinical coherence and resource requirements.

In general, the Commission believes that changes of this type should be substantiated by an empirical evaluation. The Secretary should subject this information to public analysis.

Proposed Removal of a Code from the CC list. -- The Secretary stated that ICD-9-CM code 795.8, positive serological or viral finding for HTLV-

III/LAV, was inadvertently placed on the list of CCs in the fiscal year 1987 Grouper program. The Secretary removed the codes from the CC list based on medical advice that a positive serological or viral finding, absent any symptoms or diagnosis of AIDs, would not significantly alter the course of patient care.

Based on consultation with AIDs experts, the Commission agrees with the Secretary's reasoning in removal of ICD-9-CM code 795.8 from the complication and comorbidities list.

New Coding Changes. -- The Secretary implemented new codes recommended by the ICD-9-CM Coordination and Maintenance Committee. The Commission generally supports the Secretary's establishment of new codes to further improve the ability of ICD-9-CM to respond to changing technology and medical practice. The Commission, however, has not done any extensive evaluation of the appropriateness of the noted DRG assignments for the codes. The Commission believes that appropriate coding guidelines and instructions by the Secretary with input from coding experts should be developed and disseminated to assure that the codes are used appropriately.

BENEFICIARY AND QUALITY CONCERNS

Inpatient Hospital Cost-Sharing Requirements

Cost sharing borne by Medicare beneficiaries has inadvertently increased as a result of PPS. Although Congress legislated a change in formula that will limit future increases, beneficiaries are still paying a higher proportion of inpatient hospital payments per case than before PPS. In 1983, beneficiary deductibles and coinsurance accounted for about 8.0 percent of payments to hospitals for inpatient services. Under current law, the proportion for 1987 is 9.2 percent.

The Commission recommended that the proportion of inpatient hospital payments borne by Medicare beneficiaries be returned to its pre-PPS level. Futhermore, the Commission believes that the structure of inpatient hospital cost-sharing requirements should be consistent with PPS incentives. In particular, current coinsurance and spell of illness requirements need to be reexamined. The Secretary indicated that this problem is resolved by changes in OBRA and by stabilizing lengths of stay. In addition, the Secretary notes that the Department's catastrophic health proposal modifies beneficiary cost-sharing.

The Commission supports current legislative efforts to restructure inpatient hospital cost-sharing requirements. If a catastrophic benefit

package is not implemented in fiscal year 1988, however, the Commission is pleased that the Secretary will examine policies relating to deficiencies in the cost-sharing structure. Several critical deficiencies are cited in the Commission's April 1987 recommendations. These include the inpatient hospital cost-sharing structure, the spell of illness requirements, and the consistency of these requirements with PPS incentives. In addition, if a catastrophic package is not enacted, the Commission believes that the proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its pre-PPS level.

Evaluating the Result of PRO Quality of Care Review

There has been concern since PPS was implemented that the financial incentives for hospitals to improve efficiency and productivity could reduce the quality of care furnished to Medicare beneficiaries. The Commission therefore recommended that the Secretary promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings.

In response to this recommendation, the Secretary states that a process of substantial evaluation of the impact of PRO review on the patterns of quality of care has begun. The Secretary mentions several ongoing review activities and states that the Department's data analysis at the end of the PRO contract period (1988) will enable evaluation of PRO quality activities. He further states that a procedure for public release of information used in making PRO contract decisions is being developed.

We are pleased that these efforts are underway. However, the Department's efforts seem to be tied to administration of the PRO contracting process. We continue to believe that in addition a substantial, independent assessment of PRO findings and impacts on quality of are is required. Such an evaluation would be a useful adjunct to reviews related to the PRO administrative contracting process.

APPENDIX A

RECOMMENDATION OF UPDATE FACTOR FOR RATES OF PAYMENT FOR INPATIENT HOSPITAL SERVICES, Health Care Financing Administration, HHS, Final Notice (52 Federal Register 33141), September 1, 1987

SUMMARY OF MAJOR PROVISION

Update Factor for Prospective Payment Hospitals

The notice includes the Secretary's recommended fiscal year 1988 update factors for both PPS and excluded hospitals. Because the update factors have already been set by law, the notice does not have the weight of a proposed regulation. It responds to a Congressional requirement that the Secretary recommend an update factor that would, if accepted, replace the previously legislated update factor of market basket minus two percent.

The Secretary recommends an update factor of 0.75 for prospective payment hospitals.

	Percent
FY 1988 market basket forecast	4.70
Correction for FY 1986 forecast error	-0.40
Composite policy target adjustment factor	-3.55
Total	0.75

The notice states that currently available data indicate that Medicare average case-mix has increased by 0.6 percent in FY 1987. At this time, however, no offset for coding improvements is recommended.

In general, the Secretary argues that a 0.75 percent update factor is justified by high operating margins in the first two years of PPS. Although the Secretary recognizes that the "healthy profits" earned in the initial years of PPS are diminishing, a below market basket update factor is nevertheless justified. The rates in previous years were not fully adjusted for past improvements in coding, efficiency and practice patterns. The notice does not explain the method by which the minus 3.55 percent policy target adjustment factor was reached.

Update Factor for Hospitals and Units Excluded from the Prospective Payment System

The Secretary proposes an update of 1.9 percent for the target rate of increase limit for excluded hospitals and units.

	Percent
FY 1988 market basket forecast	4.7
Correction for FY 1987 forecast error	-0.4
Composite policy target adjustment factor	-2.4
Total	1.9

The Secretary recommends that the same market basket be used for both PPS and excluded hospitals, since there is little difference between the two market baskets. The recommended policy target adjustment factor for excluded hospitals is -2.4 percent, which is smaller than recommended for PPS hospitals. The Secretary agrees with ProPAC that excluded hospitals are not subject to the same incentives as PPS hospitals, but does not explain the method by which the adjustment factor was reached.

CHANGES TO THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM AND FISCAL YEAR 1988 RATES, Health Care Financing Administration, HHS, Final Rule, (52 Federal Register 33034), September 1, 1987

SUMMARY OF MAJOR PROVISIONS

Changes to DRG Classification and Weighting Factors

A. Reclassification of Alcohol and Drug Abuse DRGs

The Secretary restructured MDC 20 effective for discharges occurring on or after October 1, 1987. Alcohol and drug abuse hospitals and units currently excluded will be included in the prospective payment system beginning with the first day of a hospital's or unit's cost reporting period that begins on or after October 1, 1987.

B. Surgical Hierarchies

The Secretary reordered the surgical hierarchies in each MDC, except MDC 7, based on the 1986 PATBILL data that will be used for recalibrating the DRGs for FY 1988.

C. Recalibration of DRG Weights

The Secretary recalibrated the DRG weights based on charge data for Medicare discharges occurring in FY 1986.

The Secretary used a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. For the low-volume DRGs, (32 DRGs contain fewer than 10 cases), the Secretary kept the relative weight the same.

Changes to Hospital Wage Index Methodology

The Secretary computed the national average hourly wage by dividing the total wages for all hospitals by the total hours paid. This results in a wage index that is hour-weighted rather than area-weighted. Using this methodology, the Secretary adopted a blended wage index that combines the wage index based on 1982 data and a new wage index based on 1984 data.

Inclusion of Puerto Rican Hospitals in the PPS

As required by statute, the Secretary will incorporate Puerto Rican hospitals in the prospective payment system. The payment per discharge for such hospitals will be the sum of: (1) 75 percent of the Puerto Rico discharged-weighted urban or rural standardized rate; and (2) 25 percent of a national discharge-weighted standardized rate.

Other Decisions and Changes to Regulations

A. Review of DRG Assignments

The Secretary included the provisions of the manual instructions concerning hospitals' requests for review of DRG assignment in the regulations. The Secretary specified that a hospital has 60 days to request a review by the intermediary of a DRG assignment. In addition, the regulation provides that a PRO must review every case in which a higher-weighted DRG is assigned to a discharge as a result of the intermediary's review.

B. Increase in the Prospective Payment Rates and Rate-of Increase Limits

As required by statute, the applicable percentage increase for fiscal year 1988 is the market basket percentage increase minus 2.0 percentage points, which is 2.7 percent.

C. Payment for Outlier Cases

A provision in OBRA 1986 created separate outlier contributions for urban and rural hospitals rather than continuing payment for outliers from a single contribution. Fiscal year 1988 standardized amounts for rural hospitals are reduced by 2.5 percent; for urban hospitals, 5.6 percent. Together, urban and rural outlier payments are estimated to be about 5 percent of standardized amounts, as the PPS statute allows.

D. Payment to Sole Community Hospitals

The Secretary clarified the regulations regarding additional payment for volume adjustments for sole community hospitals (SCHs). The Secretary clarified that any hospital receiving payments that are greater than the hospital's Medicare inpatient operating costs would not be granted any further adjustment.

In addition, the Secretary clarified that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under PPS, including outlier and indirect medical education payments.

The Secretary amended the current regulatory requirement that "the decline in the hospital's total discharges must be due to extraordinary circumstances beyond the hospital's control," by deleting the word "extraordinary."

E. Payment for the Services of Nonphysician Anesthetists

The Secretary conformed the regulations to implement the OBRA 1986 changes. Payment for the services of nonphysician anesthetists will be made on a reasonable cost basis for cost reporting periods beginning before January 1, 1989. OBRA 1986 further authorized direct billing for the services of nonphysician anesthetists on a reasonable charge basis under part B effective with services furnished on or after January 1, 1989.

Other ProPAC Recommendations

A. Timely Availability of Medicare Cost Report Data (Recommendation 6)

The Secretary concurred with ProPAC. In addition, the Secretary is prepared to work with ProPAC staff to implement a system for extrapolating estimated yearly costs from four months of data.

B. Improving the Definition of Hospital Labor Market Areas (Recommendation 12)

The Secretary did not believe further division of the wage index beyond MSA/non-MSA distinction would be appropriate absent additional study and analysis.

The Secretary stated that subdividing urban areas into core and ring, while improving the explanatory power of the wage index, would significantly increase the number areas containing only one or two hospitals. As a result, hospitals in these areas would enjoy a pass-through of labor costs. The Secretary also believed that the population-density basis for classifying urbanized areas is not stable and is updated only every 10 years. In addition, he believed that the information was not currently available to determine whether a hospital was located in an urbanized or nonurbanized area.

The Secretary used a similar explanation to reject the notion of subdividing rural areas. Also, the Secretary believed that any analysis of redefined labor markets must be considered in the context of the payment effects on hospitals.

C. Improving the Area Wage Index (Recommendation 13)

The Secretary in principle agreed with ProPAC. As mentioned earlier, the Secretary used an updated blended wage index for FY 1988. The data, however, are not broken down by occupational category. The Secretary will investigate the necessity and feasibility of putting in a place a process for obtaining the necessary data on a regular basis.

D. Extension of Volume Protection to all Isolated Rural Hospitals (Recommendation 14)

The Secretary is evaluating whether or not to seek legislation recommended by ProPAC or alternative legislation. The Secretary stated that he was uncertain about the extent of the problem ProPAC identified, and unsure that the adjustment for volume decline is appropriate.

E. Clarification of SCH Volume Exception Criteria (Recommendation 15)

The Secretary agreed, has drafted instructions and will attempt to expedite clearance of them. The Secretary, however, did not believe the process can be simplified given the need for specific information.

F. Evaluation of Current PPS Policies for Rural Hospitals (Recommendation 16)

The reports Congress mandated are in the process of being prepared.

G. Inpatient Hospital Cost-Sharing Requirements (Recommendation 18)

The Secretary believed that the Department's recent catastrophic health proposal would further restructure the benefit package and modify beneficiary cost-sharing provisions. In addition, the Secretary felt that the OBRA provisions limiting the increase in deductible amounts resolved this concern. However, the Secretary stated his intention to continue to study this problem in the event catastrophic legislation was not enacted.

H. Evaluating the Results of PRO Quality of Care Review (Recommendation 19)

The Secretary agreed and has begun a process to assess the impact of PRO review on patterns of quality of care.

I. Improving the Measurement of Hospital Case Mix (Recommendation 20)

The Secretary concurred with the recommendation. The Secretary will continue research aimed at improving the measurement of case mix to better account for variation in resource use. Research is also being pursued in the area of developing additional sources of patient information not currently available from the discharge abstract.

J. Updating the Surgical Hierarchies and the List of Operating Room Procedures (Recommendation 23)

The Secretary supported the recommendation from the standpoint of annual review and revision. He agreed that the clinical input should be combined with empirical analysis in any broad-based revision of the procedure groups. However, he was not persuaded that there is a present need for such broad-based revision.

K. Additional Payment for MRI (Recommendation 27)

The Secretary appreciated ProPAC's concern, but regards the concern as anticipatory. The Secretary has, however, approved unique ICD-9-CM codes for MRI services, effective October 1, 1986. If the Secretary finds that the payment methodology adversely affects the quality of care, alternative payment options, including add-ons, would be considered.

L. Research on Case-Mix Change (Recommendation 28)

The Secretary concurred with the need to conduct a study at the case level that can distinguish cases for case-mix change and provide the basis for monitoring case-mix change over time. However, the Secretary is concerned that the resources required are greater than the benefit that would result. While not committing themselves to undertaking a full study, the Secretary states his intention to work with ProPAC on feasibility studies.

PPS Rates for Fiscal Year 1988 (Assuming a 2.7% update)

NATIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

URBAN		RURAL	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,337.09	$828.12	$2,123.20	$587.97

ADJUSTED STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

Puerto Rico

URBAN		RURAL	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,046.38	$367.93	$1,266.46	$260.43

National

Labor-related	Nonlabor-related
$2,285.09	$769.74

CAPITAL PAYMENTS UNDER THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM Health Care Financing Adminstration (HCFA), HHS Final Rule - September 1, 1987 (52 Federal Register 33168)

SUMMARY OF MAJOR PROVISIONS

The regulation is similar to the Commission's recommendations to incorporate capital-related costs into the prospective payment system. Capital will be included into PPS effective with cost report periods beginning on or after October 1, 1987. The regulation separates capital into two components, fixed and moveable. The transition for fixed capital is eleven years, with payments heavily weighted to the hospital-specific portion in the earlier years. (The regulations refer to this as a ten-year transition.) The transition for moveable capital is eight years with payments also heavily weighted to hospital-specific portions in the earlier years. (The regulations refer to this as a seven-year transition.) The OBRA 1986 reductions are taken equally from both the federal rate and the hospital-specific portion, as the Commission recommended. In the final regulation a capital exceptions process was added.

The major provisions of the regulations are:

- National urban and rural capital rates will be established separately for plant/fixed equipment and for moveable equipment.
- The federal rates will be based on capital-related costs for cost reporting periods beginning in federal fiscal year 1984.
- These costs will be updated to federal fiscal year 1987 by an estimate of the actual rate of increase in inpatient capital costs. The rates for fiscal years 1988 and 1989 will be updated by the actual rate of increase, subject to budget neutrality adjustments. For fiscal years 1990 and onward, the rates will be updated by the PPS update factor.
- These rates will be standardized for case-mix index, indirect teaching, and disproportionate share adjustments.
- The federal payment rates for fixed capital will be adjusted by a construction cost index.
- A portion of the Federal capital payment will be added to the pool set aside for outlier payments.

- Hospital-specific payments will be based on the hospital's allowable capital-related costs for plant and fixed equipment and moveable equipment in each year of the transition, subject to the full OBRA 1986 reductions (7 percent in fiscal year 1987 and 10 percent in fiscal year 1988).

- Plant and fixed equipment will be phased-in over an eleven-year period, heavily weighted to the hospital- specific portion in the early year.

- Moveable equipment will be phased-in over an eight-year period heavily weighted to the hospital-specific portion in the early years.

- Hospitals whose actual allowable inpatient capital costs, not paid through the hospital-specific payments, are 175 percent or greater than their Federal capital payment will receive additional payments. The payment will recognize 70 percent of the difference between the hospital's allowable costs and 175 percent of the Federal capital payments. Total capital payments would be reduced by 5 percent to fund the capital exceptions payment pool.

Federal Capital-Related Portions

Fiscal year	Fixed Capital	Moveable Capital
1988	5	5
1989	10	10
1990	15	15
1991	20	20
1992	25	30
1993	30	50
1994	40	75
1995	50	100
1996	65	100
1997	80	100
1998	100	100

- Sole Community Hospitals will be exempt for cost reporting periods beginning before October 1, 1990.

- The federal rates for fiscal year 1988 are:

Plant/fixed capital		Moveable capital	
Urban	Rural	Urban	Rural
$180.03	$160.86	$122.39	$92.72

MEDICARE PROGRAM CHANGES TO THE DRG CLASSIFICATION SYSTEM, Final Notice, September 1, 1987, (52 Federal Register 33143)

SUMMARY OF MAJOR PROVISIONS

Changes Affecting Particular MDCs

A. Cochlear Impacts (MDC 3)

The Secretary agreed with ProPAC that cochlear implant cases are not clinically coherent with other cases assigned to DRG 49. However, based on the only Medicare data available to date, there would be no material differences in the weighting factors for new cochlear implant DRG and for the existing DRG 49. Since three unique ICD-9-CM codes for cochlear implants have been adopted, the Secretary stated that the procedures can be tracked without the creation of a new DRG.

B. Mechanical Ventilation Patients (MDC 4)

The Secretary felt that the classification system should recognize the higher resources associated with mechanical ventilation of patients in MDC 4, diseases and disorders of the respiratory system. Therefore, two new interim DRGs for MDC 4 were created. Cases presenting a principal diagnosis in MDC 4 and one of the tracheostomy procedure codes will be assigned to new DRG 474. Cases presenting a principal diagnosis in MDC 4 and involving both non-OR procedure codes and mechanical ventilation through endotracheal intubation will be assigned to new DRG 475.

The notice emphasized that the creation of these DRGS should be viewed only as an interim measure.

C. Diseases and Disorders of the Circulatory System (MDC 5)

The notice reassigned several procedure codes, -- 38.46 (abdominal artery resection with replacement), 38.47 (abdominal vein resection with

replacement) and 38.48 (lower limb artery resection with replacement) -- from DRG 112 (Vascular Procedures except major reconstruction without pump) to DRGs 110 and 111 (Major vascular procedure without pump with CC and without CC)

The Secretary will work with the ICD-9-CM user community to develop more specific guidelines for use of acute myocardial infarction diagnosis codes.

Heart failure unspecified (code 428.9) will be included in DRG 124, circulatory disorders, except AMI with cardiac catheterization and complex diagnosis.

New ICD-9 CM codes for pacemakers become effective October 1, 1987 that will serve as a basis for data collection on pacemakers by device type. The Secretary stated that these new codes will serve a basis for future modification, if necessary.

The Secretary altered the current classification of automatic implantable cardioverter defibrillator (AICD) cases. AICD cases with cardiac catherization procedures will continue to be assigned to DRG 104 while those without such procedures will be assigned to DRG 105. In addition, AICD replacement cases would be reassigned from DRG 117 to DRG 120.

D. Diseases and Disorders of the Digestive System (MDC 6)

Chronic gastric ulcer without mention of hemorrhage (code 531.70) will be reassigned to DRGs 177 and 178 - uncomplicated peptic ulcer from DRG 176, complicated peptic ulcer.

E. Other changes

The notice included changes to other particular MDCs including certain femur procedures, and alcohol/drug diagnoses.

Changes Affecting Multiple MDCs

A. Elimination of age over 69

The Secretary eliminated age over 69 as a criterion for DRG classification. Age under 18 in pediatric diagnosis and age 35 in diabetic DRGs will continue to be used.

B. Refinement of complications and comorbidities listing

The notice modified the Grouper logic so that certain diagnoses generally included on the list of CCs will not be considered valid in connection with particular principal diagnoses.

C. Surgical Hierarchies

Changes to surgical hierarchies were implemented.

Changes to Reduce Inappropriate DRG 468 Assignment

The major changes will be to:

- o Reassign intra-abdominal hemangioma codes;
- o Remove codes for minor skin procedures from the surgical list;
- o Add lymphatic structure biopsy to MDC 1;
- o Add total splenectomy to MDC 5;
- o Add certain pancreas procedures codes to MD 10;
- o and several others

Coding Issues

The notice removed certain codes from the surgical list and made other coding changes.

APPENDIX B

SUMMARY OF COMMISSION APRIL 1987 UPDATE RECOMMENDATIONS AND THE SECRETARY'S RESPONSES

This appendix provides a summary of ProPAC's 1987 recommendations and the Secretary's responses. The appendix is organized as follows:

- First, the Commission recommendation is provided.
- Second, the Secretary's response to the recommendation is summarized. His response was contained in the Notices of Proposed Rulemaking (NPRMs) and the Proposed Notices.
- Third, a summary of ProPAC's formal comments is provided. These comments are taken from the Commission's response to the NPRMs and Proposed Notices that were submitted to HHS on July 17, 1987.
- Finally, the Secretary's final regulatory action is summarized. This information is taken from the final regulations and notices promulgated September 1, 1987.

It is important to note that in Pub. L. 100-119, Congress delayed the effective date of the update factor and the inclusion of capital into PPS until November 21, 1987. In addition, it is likely that Congress will pass legislation that modifies some of the Secretary's regulatory provisions and implements some of the Commission's recommendations. Further, in the event Congress does not achieve the deficit reduction required under Pub. L. 100-119, Medicare payments will be reduced through sequestration up to a maximum of 2 percent.

ProPAC Recommendation 1: Update Factor for FY 1988

For fiscal year 1988, the standardized amounts should be updated by an average 1.8 percent reduction to reflect first-year PPS cost information, the projected increase in the hospital market basket, and a discretionary adjustment factor of 0.5 percent. The DRG weights should also be adjusted downward to offset the expected increase in the average case weight during FY 1987. The net effect of these factors was estimated to result in an average update of 2.3 percent (2.2 percent for urban hospitals and 3.0 percent for rural hospitals).

Secretary's Response

The Secretary recommended an update factor of 0.75 percent for all PPS hospitals. This recommendation was submitted in response to OBRA requirements. OBRA set the PPS update factor for fiscal year 1988 at the hospital market basket minus two percent. Absent Congressional action, the update will be 2.7 percent.

ProPAC's Comment

The Commission believes that an update factor as low as 0.75 percent could have negative consequences, at least for some hospitals and the beneficiaries they treat.

Final Action

The Secretary continues to support an update of 0.75 percent for all PPS hospitals. Pub. L. 100-119 delayed the effective date of the 2.7 percent update until November 21, 1987. If Congress does act further, the update will be 2.7 percent less a maximum Gramm-Rudman reduction of two percent.

ProPAC Recommendation 2: Adjustment to the Level of Standardized Amounts

The update factor should include an adjustment to lower the standardized amounts an average of 5.4 percent, phased in over three years. The adjustment for FY 1988 should be minus 1.9 percent for urban hospitals and minus 1.1 percent for rural hospitals. These reductions reflect the Commission's judgment about how information on first-year PPS costs should be incorporated into the update factor.

Secretary's Response

The Secretary did not agree that the standardized amounts should be adjusted in the manner recommended by the Commission, nor did he believe that the update should be different for urban and rural hospitals. The Secretary asserts that with recent legislative changes a separate update factor would overcompensate rural hospitals relative to urban hospitals. The Secretary commented that the analysis conducted by ProPAC did not include outlier and teaching adjustment changes.

The Secretary agreed, however, that the update should be less than the market basket so that the Medicare program can share in the savings

from PPS. There was also agreement that this sharing should be gradual rather than abrupt.

ProPAC's Comment

The Commission's judgment that a minus 5.4 percent adjustment is appropriate is based on a recalculation of the PPS standardized amounts. Although the Secretary's recommended update factor did not include a similar adjustment to reflect PPS cost information, the discussion of the overall recommended 0.75 percent update and the minus 3.55 percent composite policy target adjustment factors suggested that this information was implicitly used.

It appears that the Secretary rejected the concept of separate urban and rural update factors based on simulated operating margins. The Commission believes that such an analysis is not relevant. The intent of the recommendation is to ensure that the standardized amounts reflect more recent information about the underlying cost differences between urban and rural hospitals. The difference between urban and rural standardized amounts would be almost identical to the difference in discharge-weighted amounts computed using first-year PPS cost data. In addition, ProPAC's analysis did include legislated changes in outlier and teaching adjustment policy.

Final Action

The Secretary did not change his position.

ProPAC Recommendation 3: Discretionary Adjustment Factor

For fiscal year 1988, the allowance in the Discretionary Adjustment Factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 0.8 percent.

Secretary's Response

The Secretary recommended a composite policy target adjustment factor (PTAF) of minus 3.55 percent. He did not provide any information to support this adjustment.

ProPAC's Comment

The Commission is disappointed that this year the Secretary chose not to provide any basis for this recommendation. The Commission believes it is

important to maintain a consistent methodology for developing the discretionary adjustment factor. The Commission doubts that use of a consistent methodology would lead to a judgment that a minus 3.55 percent adjustment is appropriate. Without any supporting evidence, the Commission believes this adjustment is an unreasonable reduction in payment to the hospital industry.

Final Action

The Secretary did not change his position.

ProPAC Recommendation 4: Adjustments for Case-Mix Change

For fiscal year 1988, the update should include a positive allowance of 1.3 percent in the Discretionary Adjustment Factor for estimated real case-mix change and an across-the-board reduction of 1.3 percent in the DRG weights to offset the estimated increase in the average DRG weight during fiscal year 1987. The net effect of these adjustments was estimated by the Commission to be zero.

Secretary's Response

The Secretary did not recommend case-mix related adjustments for either real case-mix change or for coding improvements. The Secretary reported, however, that the average case weight increased 0.6 percent in fiscal year 1987 based on preliminary evidence.

ProPAC's Comment

The Secretary's treatment of no case-mix change is consistent with the Commission's recommendation based on an estimate of offsetting real case-mix change and upcoding. Based on information provided by the Secretary, however, ProPAC modified the case-mix change components of its update recommendation. The Commission believes that continued monitoring of real case-mix change, both across and within DRGs, is important.

Final Action

The Secretary did not comment further on ProPAC's response.

ProPAC Recommendation 5: Update Factor for Excluded Hospitals and Distinct-Part Units

For fiscal year 1988, the target rate of increase factor for excluded hospitals and distinct-part units should be set at the market basket forecast minus a 0.5 percent combined adjustment for productivity improvement and scientific and technological advancement. This update factor was estimated to be 4.2 percent.

Secretary's Response

The Administration recommended an increase in the target-rate-of-increase limit of 1.9 percent for all excluded hospitals and units.

ProPAC's Comment

The Commission is pleased that the Secretary recommended a separate and higher update factor for PPS-excluded hospitals and units. The Commission, however, is concerned that an increase of 1.9 percent is too low. Without any supporting data, the Commission is unable to evaluate the merits of the Secretary's arguments. In addition, based on information provided in the notice, the Commission modified its update recommendation for excluded hospitals and units to 4.2 percent.

Final Action

The Secretary did not change his position. Pub. L. 100-119 delayed the implementation of the update factor until November 21, 1987. Absent Congressional action, the update factor for fiscal year 1988 is 2.7 percent.

ProPAC Recommendation 6: Timely Availability of Cost Data

Medicare Cost Report data should be collected routinely from a sample of PPS hospitals that have accounting years beginning during the first four months of the Federal fiscal year.

Secretary's Response

The Secretary concurred with ProPAC. In addition, the Secretary is prepared to work with ProPAC staff to implement a system for extrapolating estimated yearly costs from Medicare cost report data pertaining to hospitals with early accounting years.

ProPAC's Comment

The Commission is pleased at the Secretary's willingness to work jointly with ProPAC on this project.

Final Action

No further action.

ProPAC Recommendation 7: All-Inclusive Rate

The Secretary should initiate a transition to a new capital payment method beginning in federal fiscal year 1988. This method should combine operating and capital cost components in a single prospective payment per case.

Secretary's Response

The Secretary agreed that the transition to a prospective capital payment method should begin in Federal fiscal year 1988. The Secretary also stated his preference for a method that combined both operating and capital payments into a single prospective payment per case, as the Commission recommended. Due to the special treatment that must be accorded capital, (e.g., construction cost index, updating factors, and transition), a single prospective rate could not be developed.

ProPAC's Comment

The Commission concurs with the Secretary.

Final Action

Pub. L. 100-119 delayed the implementation of prospective capital payment until November 21, 1987. Further, it appears that Congress may continue cost reimbursement for capital, subject to reductions, for an additional period.

ProPAC Recommendation 8: Level of Federal Capital Payment

Capital should be added to the Federal portion of PPS payments at a level consistent with that established by OBRA of 1986. The level for fiscal years 1988 and 1989 should be based on official Medicare inpatient projections in fiscal year 1987. The projections should include all capital components as presently determined on a reasonable cost basis.

Secretary's Response

The Secretary concurred with the recommendation.

ProPAC's Comment

The Commission is concerned that the federal capital payment rates published in the rule appeared to be low. The Commission believes that the process of standardizing the average federal cost per case could reduce the rates significantly. The Commission recommends that the Secretary publish the information used in calculating the rates.

Final Action

No further action.

ProPAC Recommendation 9: Capital Payment Transition

The transition to Federal capital payments should occur in the following manner: (1) payments for fixed capital should be phased-in over an eleven-year period on a straight-line basis, and (2) payment for moveable capital should be phased-in over a three-year period on a straight-line basis. Hospital-specific fixed and moveable capital payment portions should be based on the actual capital costs incurred during each year of the transition.

Secretary's Response

The Department generally followed ProPAC's recommendation. The transition for fixed capital, however, uses a blending schedule weighted more heavily to the hospital's actual costs in the early years.

ProPAC's Comment

The Commission prefers the straight-line transition in contrast to a transition weighted toward hospital-specific payments in the early years.

Final Action

The Secretary extended the transition for moveable capital to eight years using a blending schedule weighted more heavily to hospital-specific payments in the earlier years.

ProPAC Recommendation 10: Institution Neutrality

Until the start of the transition to an all-inclusive PPS payment rate, the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities.

Secretary's Response

The Secretary did not accept ProPAC's recommendation. He stated that the rebundling provisions under PPS required that all nonphysician services and items must be furnished to inpatients by the hospital either directly or under arrangement. Further, in developing the initial prospective payment rates, adjustments were made to account for items and services furnished outside of the hospital that were not previously the financial liability of the hospital. The adjustments were based on charge data and did not distinguish between operating and capital costs. As a result, the Secretary believed that the Federal standardized amounts for inpatient operating services already reflect an estimate of the full costs, including capital, of items and services furnished by outside entities.

In addition, because the proposed regulations would incorporate capital into the prospective payment system, this recommendation would not need to be implemented.

ProPAC's Comment

The Commission disagrees with the Secretary. The Commission is not convinced that the standardized amounts for inpatient operating services reflect the capital costs of services furnished at other facilities. This is particularly true with new capital-intensive technologies that were not available prior to PPS.

Final Action

No further action.

ProPAC Recommendation 11: Capital Exceptions Process

The Secretary should develop an exceptions policy to assist hospitals that are vulnerable to financial hardships when capital payment is included under PPS. Hospital eligibility criteria should emphasize the goal of ensuring continued access of Medicare beneficiaries to high-quality hospital services. A limited dollar pool should be made available with

strict criteria used to determine which hospitals should be eligible for a capital payment adjustment.

Secretary's Response

The Secretary reasoned that the proposed transition would reduce the possibility of financial hardship as a result of a change in policy. The Secretary stated that a distinct exceptions policy would be considered if, during the transition years, the standardized capital payments cause financial difficulties for hospitals resulting in reduced access to high quality hospital services for Medicare beneficiaries.

ProPAC's Comment

The Commission is encouraged that the Secretary did not reject totally the idea of an exception process. The Commission urges further consideration of an exceptions process. ProPAC's analysis indicated that some hospitals will be vulnerable as a result of the inclusion of capital into PPS.

Final Action

The Secretary adopted an exceptions process. A hospital would receive additional payments if its actual allowable inpatient costs not paid through the hospital-specific portion are 175 percent, or greater, than its Federal capital payments. The hospital would receive 70 percent of the difference between its actual allowable costs and 175 percent of its Federal capital payments. Total capital payments would be reduced by 5 percent to fund the exceptions payments pool.

ProPAC Recommendation 12: Improving the Definition of Hospital Labor Market Areas

The Secretary should adopt improved definitions of hospital labor market areas that for urban areas distinguish between central and outlying areas and for rural areas that distinguish between urbanized rural areas and other rural areas.

Secretary's Response

The Secretary did not accept that further division of the wage index beyond MSA/non-MSA distinction would be appropriate absent additional study and analysis.

The Secretary stated that subdividing urban areas into core and ring, while improving the explanatory power of the wage index, would significantly increase the number of areas containing only one or two hospitals. As a result, the Secretary believes that hospitals in these areas would receive a pass-through of labor costs. The Secretary also believes that the population-density basis for classifying urbanized areas is not stable and is updated only every 10 years. In addition, the Secretary questions whether the information is available to determine if a hospital is located in an urbanized or nonurbanized area.

The Secretary used a similar explanation to reject the notion of subdividing rural areas. Also, the Secretary argued that any analysis of redefined labor markets must be considered in the context of the payment effects to hospitals.

ProPAC's Comment

The Commission strongly disagrees with the Secretary's response. The Secretary was required by statute to collaborate with ProPAC and was to report to Congress on methods of improving hospital labor market areas by May 1987. ProPAC's recommendations were based on a major study which has been shared with the Secretary's staff. The Commission was further disappointed by the limited extent of collaboration of the Secretary with ProPAC on our study in particular and this issue in general.

The Commission believes, unlike the Secretary, that the intent of the area wage adjustment is to account for input price variation between different labor markets. ProPAC's recommendation accounts for a greater amount of wage variation and therefore represents a technical improvement in the adjustment. While ProPAC's recommendation would increase the percentage of urban labor markets with fewer than three hospitals from 21 percent to 39 percent, the Commission disagrees with the Secretary's claim that this will result in a pass-through for hospitals in these areas.

Finally, the Census Bureau has assured ProPAC that it is possible to make a determination as to whether hospitals are located in urbanized or nonurbanized areas.

Final Action

The Secretary continued to reject ProPAC's recommendation. The Secretary asserted that HCFA's research indicated that adoption of this recommendation would result in abrupt changes in the distribution of payments. In addition, the Secretary did not agree with ProPAC that this

recommendation would provide any greater explanatory power for variation in hospital costs. Finally, the Secretary continued to assert that data are not available to determine a hospital's location in an urbanized area. However, the Secretary indicated that an active review of refinements to labor market areas was underway.

ProPAC Recommendation 13: Improving the Area Wage Index

The Secretary should update the hospital wage data necessary for calculating the area wage index regularly. This updated information should include data by hospital occupational categories.

Secretary's Response

The Secretary agrees with ProPAC in principle. As mentioned earlier, the Secretary proposes to use an updated blended wage index for FY 1988. The data, however, are not broken down by occupational category. The Secretary will investigate the necessity and feasibility of obtaining the necessary data on a regular basis.

ProPAC's Comment

The Commission is pleased with the Secretary's intention to update the wage index regularly and to collect information according to occupational categories. The Commission also intends to further examine the feasibility of collecting wage data on a regular basis.

Final Action

No further action.

ProPAC Recommendation 14: Extension of Volume Protection to all Isolated Rural Hospitals

The Secretary should seek legislation to expand the eligibility for a PPS volume adjustment to all isolated rural hospitals that meet the criteria for Sole Community Hospitals. Eligibility should not be limited to those which have obtained such status.

Secretary's Response

The Secretary is evaluating whether to seek legislation recommended by ProPAC or alternative legislation. The Secretary stated that the extent

of the problem ProPAC identified is uncertain. Thus, the Secretary was unsure whether the adjustment for volume decline is appropriate.

ProPAC's Comment

The Commission is pleased that the Secretary is examining legislative alternatives to address the needs of small isolated rural hospitals. The Commission did not suggest that this recommendation was a panacea to the problems facing rural hospitals. However, the Commission believes that expansion of the volume adjustment is required to ensure payment equity among providers that qualify for sole community hospital status.

Final Action

No further action.

ProPAC Recommendation 15: Clarification of SCH Volume Exception Criteria

The Secretary should issue instructions for implementing the SCH volume adjustment before fiscal year 1988 begins. The instructions should clarify the interpretation of the criteria used to grant an adjustment and the application process should be simplified.

Secretary's Response

The Secretary agrees, has drafted instructions, and will attempt to expedite clearance of them. The Secretary, however, did not believe the process can be simplified because of the need for specific information.

ProPAC's Comment

The Commission urges the Secretary to expedite the issuance of these instructions, preferably by the beginning of fiscal year 1988.

Final Action

No further action.

ProPAC Recommendation 16: Evaluation of Current PPS Policies for Rural Hospitals

The Secretary should complete the studies mandated by Congress and make them publicly available as soon as possible.

Secretary's Response

The reports Congress mandated are in the process of being prepared.

ProPAC's Comment

The Commission believes the Secretary should expedite the clearance process for these reports. The results of the Secretary's studies may prove to be critical in focusing the public debate on a subset of rural hospital policy alternatives.

Final Action

No further action.

ProPAC Recommendation 17: Improvements in Outlier Payment Policy

The Secretary should continue to review outlier payment policy and implement refinements to more accurately reflect the resources hospitals use to treat outlier cases.

Secretary's Response

The Secretary proposed a modification to the existing outlier payment policy. The proposal would increase the marginal cost for cost outliers to 80 percent of adjusted charges beyond the cost outlier threshold. If a day outlier case also meets the cost outlier criteria, payment would be based using the revised cost outlier methodology.

ProPAC's Comment

The Commission supports the Secretary's stated intent and agreed that a higher fraction of outlier payments ought to be for extremely costly cases rather than for cases with extremely long stays. The Commission is concerned, however, that the Secretary's proposed changes would not fulfill the stated intent and will have a long-term adverse effect on hospital pricing policy.

Furthermore, because the majority of outliers would be cost outliers under the proposal, the Commission believes that applying a national cost-to-charge ratio to approximate individual hospitals' costs is unwise. Therefore, the Commission opposed adoption of this change. The Commission urges the Secretary to complete the necessary analyses so that refinements can be made in the upcoming payment year.

Finally, the Commission urges the Secretary to increase outlier contributions to the maximum allowed under the statute, 6 percent of total projected payments.

Final Action

The Secretary postponed implementation of the new outlier payment policy. The Secretary will continue research on outliers, including the use of hospital-specific cost-to-charge ratios.

The Secretary rejected the idea of increasing outlier contributions to 6 percent because this change was not included in the proposed regulations. As a result, the Secretary stated that it would be inappropriate to implement this change absent public comment.

ProPAC Recommendation 18: Inpatient Hospital Cost-Sharing Requirements

The proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its pre-PPS level.

Secretary's Response

The Secretary stated that the Department's recent catastrophic health proposal would further restructure the benefit package and modify beneficiary cost-sharing provisions.

ProPAC's Comment

The Commission supports current legislative efforts to restructure inpatient hospital cost-sharing requirements. However, if a catastrophic benefit package is not implemented in fiscal year 1988, the Commission encourages the Secretary to examine and propose modifications in policies relating to apparent deficiencies in the cost-sharing structure.

Final Action

The Secretary believes that OBRA changes and stabilizing lengths of stay resolve this problem. However, the Secretary stated that if catastrophic legislation is not enacted, further study would be undertaken in order to mitigate the amounts paid by beneficiaries, subject to budgetary concerns.

ProPAC Recommendation 19: Evaluating the Results of PRO Quality of Care Review

The Secretary should promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings. The evaluation should assess the impact on quality of care of preadmission, admission, transfer, and readmission review activities. This effort is beyond the auditing and validating activities of the SuperPRO.

Secretary's Response

The Secretary believed that ProPAC's recommendation would result in a duplicative evaluation effort.

ProPAC's Comment

The Commission is aware of the activities of the SuperPRO to audit and validate PRO activities. However, this effort does not substitute for a comprehensive evaluation of the extent to which PROs are identifying, assessing, and correcting problems related to quality of care, as the Commission recommends.

Final Action

The Secretary generally concurred and initiated several PRO administrative processes to monitor the impact of PRO review on patterns of quality of care.

ProPAC Recommendation 20: Improving the Measurement of Hospital Case Mix

The Commission continues to believe that the DRG system is the most appropriate measure of hospital case mix for Medicare PPS. The Secretary should improve the measurement of case mix to better account for variation in resource use.

Secretary's Response

The Secretary concurred with the recommendation. The Secretary will continue research aimed at improving the measurement of case mix to better account for variation and resource use. Research is also being pursued in the area of developing additional sources of patient data not currently available from the discharge abstract.

ProPAC's Comment

No Response.

Final Action

No further action.

ProPAC Recommendation 21: The Use of Patient Age in Defining DRGs

DRGs should not be defined based on the current variable of age greater than 69 and/or presence of a complication or comorbidity (CC). DRGs should be defined on the basis of the presence or absence of a CC, regardless of age. The Secretary should also determine whether other DRGs should be split on CC.

Secretary's Response

The Secretary concurred with ProPAC's recommendation and proposed to eliminate age over 69 as a criterion for DRG classification.

ProPAC's Comment

The Commission is pleased that the Secretary accepted its recommendation. The Commission urges the Secretary to study other DRGs that currently do not split on age and CC. Some of these DRGs may now need to be split using the CC only criterion.

Final Action

The Secretary agreed that it is necessary to investigate whether the presence of CC significantly affects resource consumption in those DRGs that currently do not split on CC. The Secretary will review this issue and report the Department's findings in the future.

ProPAC Recommendation 22: Improving the List of Complications and Comorbidities in Defining DRGs

The Secretary should revise the current list of CCs and its use in defining DRGs, to ensure more appropriate grouping of Medicare cases for payment under PPS. The Secretary should evaluate several possible approaches, including the development of MDC or DRG-specific CCs on the basis of resource intensity, and the specification of levels of complexity among the CCs.

Secretary's Response

The Secretary proposed to modify the Grouper logic so that certain diagnoses generally included on the list of CCs would not be considered valid CCs in connection with a particular principal diagnosis.

ProPAC's Comment

The Commission supports the Secretary's efforts. However, the Secretary stated that the proposed changes are based generally on ICD-9-CM coding rules. This is not always apparent from the notice. The Commission urges the Secretary to clearly distinguish between coding rules required for hospital reporting purposes and the application of such rules by the Grouper logic for payment purposes.

In addition, the Secretary should provide an analyses of the financial impact of these changes. The Commission believes such an analysis is critical.

Final Action

The Secretary corrected an error in the proposed regulation regarding coding guidelines.

ProPAC Recommendation 23: Updating the Surgical Hierarchies and the List of Operating Room Procedures

The Secretary should evaluate the surgical hierarchies periodically. They should be updated to determine both the clinical appropriateness and resource intensity of the procedures within each class and the relative order of the modified surgical classes.

Secretary's Response

The Secretary supported the recommendation from the standpoint of annual review and revision. The Secretary was not persuaded, however, that the ordering of procedure groups should be determined by clinicians. The Secretary believed that hospital resource intensity should serve as the basis for ranking DRGs.

ProPAC's Comment

The Commission is pleased that the Secretary supported its recommendation. The Commission reiterates its belief that the surgical

procedures within each procedure group should be evaluated on a regular basis. The Secretary's response did not address this aspect of the Commission's recommendation.

Further, the Secretary's response did not accurately represent the Commission's position regarding the use of clinical expertise. The Commission states that clinical expertise should be combined with empirical analysis, using the most recent data on the resource intensity of procedures, to produce revised procedure groups. The Commission did not recommend that clinicians should determine the order of revised procedure groups as the Secretary indicated.

Final Action

The Secretary agreed with ProPAC that clinical expertise should be combined with empirical analysis in any broad-based revision of the procedure groups. However, the Secretary was not persuaded that there was a present need for such broad-based revision. The Secretary stated that absent a complaint or concern regarding classification of particular types of cases, he was not convinced that the limited staff resources would be best utilized on a project "tantamount to reinventing the surgical DRGs."

ProPAC Recommendation 24: Improving Grouper Logic and ICD-9-CM Coding

The Secretary should develop and implement changes to ICD-9-CM and the use of these codes by the DRG Grouper. More consistent guidelines should be developed for the selection of principal diagnosis and sequencing of other diagnoses. The Secretary should review all the codes in Chapter 16 of the coding system to establish consistent coding rules and guidelines and help ensure more appropriate DRG assignment.

Secretary's Response

The Secretary concurred in principle stating that the ICD-9-CM Coordination and Management Committee should address ProPAC's concern. The Secretary will continue to devote resources to making needed improvements and encourages suggestions for improvements.

ProPAC's Comment

No Response.

Final Action

No further action.

ProPAC Recommendation 25: Temporary DRG for the Implantable Defibrillator

Implantable defibrillator cases should be assigned to a new, temporary, device-specific DRG.

Secretary's Response

The Secretary did not agree with ProPAC's recommendation. Automatic implantable cardiac defibrillator (AICD) cases with cardiac catheterization (and presumably electrophysiologic studies) would continue to be assigned to DRG 104. Cases without cardiac catheterization would be assigned to DRG 105. AICD replacement cases would be reassigned from DRG 117 to 120.

ProPAC's Comment

The Commission, in general, supports the Secretary's proposed modifications. However, there are problems associated with long delays in assigning ICD-9-CM codes to new technologies and procedures and obtaining Medicare program data. These delays prevent early evaluation of the appropriateness of DRG assignment. The Commission recommends that the Secretary consider temporary, device-specific DRGs using the best available data to set a weight during the early phase of a new technology.

Final Action

The Secretary did not agree that there are long delays in assigning ICD-9-CM codes to new technologies and procedures.

ProPAC Recommendation 26: Temporary DRG for the Cochlear Implant

Cochlear implant cases should be assigned to a new, temporary, device-specific DRG.

Secretary's Response

The Secretary did not concur with ProPAC's recommendation. Three unique ICD-9-CM codes have been adopted for cochlear implant cases to allow for the tracking of such procedures without creating a new DRG.

ProPAC's Comment

The Commission believes that classification of cochlear implant cases into DRG 49 is inappropriate in terms of resource consumption and clinical coherence. The Commission recommends that the Secretary consider temporary, device-specific DRGs using the best available data to set a weight during the early phase of a new technology.

Final Action

The Secretary did not agree. In addition, the Secretary stated that based on partial fiscal year 1987 Medicare billing data the standardized charge for cochlear implant cases was slightly less than the standardized charge for other cases assigned to DRG 49. The Secretary believes that, wherever possible, Medicare data should be used to establish DRG weights to ensure consistency.

ProPAC Recommendation 27: Additional Payment for MRI

For a three-year period, Medicare should pay hospitals an additional amount (called an add-on), to reflect operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital.

Secretary's Response

The Secretary appreciated ProPAC's concern, but regards the concern as anticipatory. The Secretary had, however, approved unique ICD-9-CM codes for MRI services, effective October 1, 1986. If the Secretary finds that the payment methodology adversely affects the quality of care, alternative payment options, including add-ons, would be considered.

ProPAC's Comment

The Commission believes that a special payment mechanism is needed to assure the appropriate adoption of this important new diagnostic technology.

Final Action

The Secretary did not concur. In addition the Secretary believes that the proposal would undermine the basic tenets of PPS, that the payment level made for each case is based on the average. Further, the Secretary believes that PPS should neither encourage nor discourage the diffusion of new technologies.

ProPAC Recommendation 28: Research on Case-Mix Change

The Secretary should initiate, as soon as possible, a study of case-mix change based on a reabstraction of medical records of PPS patients. The study should serve as the basis on which to develop and refine alternative ongoing data collection methods to monitor case-mix change over time. The Commission will contribute resources to designing, financing and monitoring the study.

Secretary's Response

The Secretary concurred with the need to conduct a study at the case level that can distinguish cases for case-mix change and provide the basis for monitoring case-mix change over time. However, the Secretary was concerned that the resources required are greater than the benefit that would result. While not committing themselves to undertaking a full study, the Secretary stated his intention to work with ProPAC on feasibility studies.

ProPAC's Comment

The Commission looks forward to working with the Secretary on feasibility studies.

Final Action

No further action.

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.5610	3.4434	-3.3%
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.8111	3.8160	0.1%
3	1	SURG	CRANIOTOMY AGE 0-17	2.9183	2.9183	0.0%
4	1	SURG	SPINAL PROCEDURES	2.7296	2.5904	-5.1%
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6508	1.5685	-5.0%
6	1	SURG	CARPAL TUNNEL RELEASE	0.4073	0.4393	7.9%
7	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	1.3866	2.5269	82.2%
8	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.7464	0.7367	-1.3%
9	1	MED	SPINAL DISORDERS & INJURIES	1.4235	1.2639	-11.2%
10	1	MED	NERVIOUS SYSTEM NEOPLASMS WITH CC	1.1322	1.2123	7.1%
11	1	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.9338	0.7729	-17.2%
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.0001	0.9459	-5.4%
13	1	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.9790	0.9324	-4.8%
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3143	1.2429	-5.4%
15	1	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	0.6241	0.6293	0.8%
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC	0.9042	1.0384	14.8%
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6802	0.6358	-6.5%
18	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	0.7566	0.9557	26.3%
19	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6549	0.6158	-6.0%
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.4087	1.6220	15.1%
21	1	MED	VIRAL MENINGITIS	1.3143	1.3613	3.6%
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	0.7086	0.7055	-0.4%
23	1	MED	NONTRAUMATIC STUPOR & COMA	1.1239	0.9505	-15.4%
24	1	MED	SEIZURE & HEADACHE AGE >17 WITH CC	0.7642	0.9228	20.8%
25	1	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.5520	0.5386	-2.4%
26	1	MED	SEIZURE & HEADACHE AGE 0-17	0.6255	0.5635	-9.9%
27	1	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.5645	1.4753	-5.7%
28	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	0.9422	1.1694	24.1%
29	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.6462	0.5856	-9.4%
30	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3539	0.3539	0.0%
31	1	MED	CONCUSSION AGE >17 WITH CC	0.5381	0.6550	21.7%
32	1	MED	CONCUSSION AGE >17 W/O CC	0.4064	0.4005	-1.5%
33	1	MED	CONCUSSION AGE 0-17	0.2457	0.2457	0.0%
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	0.9761	1.2038	23.3%
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.7383	0.6035	-18.3%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
36	2	SURG	RETINAL PROCEDURES	0.7101	0.6820	-4.0%
37	2	SURG	ORBITAL PROCEDURES	0.6687	0.7104	6.2%
38	2	SURG	PRIMARY IRIS PROCEDURES	0.3963	0.3779	-4.6%
39	2	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5719	0.5167	-9.7%
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.4133	0.4675	13.1%
41	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3657	0.3657	0.0%
42	2	SURG	INTRAOCULAR PROCEDURES RETINA, IRIS & LENS	0.6542	0.6600	0.9%
43	2	MED	HYPHEMA	0.3461	0.3727	7.7%
44	2	MED	ACUTE MAJOR EYE INFECTIONS	0.6395	0.6352	-0.7%
45	2	MED	NEUROLOGICAL EYE DISORDERS	0.5407	0.5595	3.5%
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 WITH CC	0.6009	0.6195	3.1%
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4187	0.3611	-13.8%
48	2	MED	OTHER DISORDERS OF THE EYE AGE 0-17	0.4018	0.4018	0.0%
49	3	SURG	MAJOR HEAD & NECK PROCEDURES	2.8742	2.8923	0.6%
50	3	SURG	SIALOADENECTOMY	0.7033	0.6681	-5.0%
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.5878	0.5424	-7.7%
52	3	SURG	CLEFT LIP & PALATE REPAIR	0.6955	0.7033	1.1%
53	3	SURG	SINUS & MASTOID PROCEDURES AGE >17	0.6175	0.6159	-0.3%
54	3	SURG	SINUS & MASTOID PROCEDURES AGE 0-17	0.6889	0.6889	0.0%
55	3	SURG	MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	0.4342	0.4598	5.9%
56	3	SURG	RHINOPLASTY	0.4357	0.4471	2.6%
57	3	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENDIDECTOMY ONLY, AGE >17	0.7717	0.7907	2.5%
58	3	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENDIDECTOMY ONLY, AGE 0-17	0.3097	0.3097	0.0%
59	3	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4130	0.3845	-6.9%
60	3	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2616	0.2616	0.0%
61	3	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	0.4273	0.5401	26.4%
62	3	SURG	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.3089	0.3089	0.0%
63	3	SURG	OTHER EAR, NOSE & THROAT O.R. PROCEDURES	1.1618	1.1538	-0.7%
64	3	MED	EAR, NOSE & THROAT MALIGNACY	0.9769	1.0548	8.0%
65	3	MED	DYSEQUILIBRIUM	0.4500	0.4600	2.2%
66	3	MED	EPISTAXIS	0.4144	0.4272	3.1%
67	3	MED	EPIGLOTTITIS	0.9363	0.9964	6.4%
68	3	MED	OTITIS MEDIA & URI AGE >17 WITH CC	0.6088	0.7217	18.5%
69	3	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.5040	0.5366	6.5%
70	3	MED	OTITIS MEDIA & URI AGE 0-17	0.5251	0.5345	1.8%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
71	3	MED	LARYNGOTRACHEITIS	0.6582	0.6026	-8.4%
72	3	MED	NASAL TRAUMA & DEFORMITY	0.5216	0.4895	-6.2%
73	3	MED	OTHER EAR, NOSE & THROAT DIAGNOSES AGE >17	0.6045	0.7404	22.5%
74	3	MED	OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	0.3427	0.3427	0.0%
75	4	SURG	MAJOR CHEST PROCEDURES	2.9776	3.0258	1.6%
76	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES WITH CC	2.5663	2.0885	-18.6%
77	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.6734	1.0970	-34.4%
78	4	MED	PULMONARY EMBOLISM	1.4798	1.4817	0.1%
79	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	1.9344	2.0777	7.4%
80	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	1.4387	1.3341	-7.3%
81	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.8652	1.1032	27.5%
82	4	MED	RESPIRATORY NEOPLASMS	1.1258	1.1899	5.7%
83	4	MED	MAJOR CHEST TRAUMA WITH CC	0.8397	0.9698	15.5%
84	4	MED	MAJOR CHEST TRAUMA W/O CC	0.5920	0.5372	-9.3%
85	4	MED	PLEURAL EFFUSION WITH CC	1.1196	1.1451	2.3%
86	4	MED	PLEURAL EFFUSION W/O CC	0.9761	0.7720	-20.9%
87	4	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.8076	1.5691	-13.2%
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0768	1.1263	4.6%
89	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.1657	1.2862	10.3%
90	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.8842	0.8961	1.3%
91	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7914	0.9448	19.4%
92	4	MED	INTERSTITIAL LUNG DISEASE WITH CC	1.1115	1.2821	15.3%
93	4	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.8641	0.8264	-4.4%
94	4	MED	PNEUMOTHORAX WITH CC	1.3044	1.3954	7.0%
95	4	MED	PNEUMOTHROAX W/O CC	0.8796	0.7571	-13.9%
96	4	MED	BRONCHITIS & ASTHMA AGE >17 WITH CC	0.8446	0.9804	16.1%
97	4	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.7091	0.7151	0.8%
98	4	MED	BRONCHITIS & ASTHMA AGE 0-17	0.7201	0.5744	-20.2%
99	4	MED	RESPIRATORY SIGNS & SYMPTOMS WITH CC	0.8072	0.7803	-3.3%
100	4	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.6253	0.5238	-16.2%
101	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	0.8460	0.9585	13.3%
102	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.6841	0.6625	-3.2%
103	5	SURG	HEART TRANSPLANT	0.0000	11.9225	NA
104	5	SURG	CARDIAC VALVE PROCEDURE W PUMP & W CARDIAC CATH	7.3151	7.3424	0.4%
105	5	SURG	CARDIAC VALVE PROCEDURE W PUMP & W/O CARDIAC CATH	6.3388	5.7811	-8.8%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
106	5	SURG	CORONARY BYPASS WITH CARDIAC CATH	5.3324	5.5415	3.9%
107	5	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.6608	4.2858	-8.0%
108	5	SURG	OTHER CARDIOTHORACIC OR VASCULAR PROCEDURES, WITH PUMP	4.7803	5.3703	12.3%
109	5	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O PUMP	4.3579	3.9142	-10.2%
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP WITH CC	3.3118	3.6718	10.9%
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP W/O CC	2.4549	2.2639	-7.8%
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.2055	1.8911	-14.3%
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LUMB & TOE	2.5345	2.4590	-3.0%
114	5	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.8918	1.7040	-9.9%
115	5	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	4.1727	4.0516	-2.9%
116	5	SURG	PERM CARDIAC PACEMAKER IMPLANT W/O AMI HEART FAILURE OR SHOCK	2.9868	2.7694	-7.3%
117	5	SURG	CARDIAC PACEMAKER REPLACE & REVIS EXCEPT PULSE GEN REPLACEMENT	1.2989	1.2261	-5.6%
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT	1.9224	1.7563	-8.6%
119	5	SURG	VEIN LIGATION & STRIPPING	0.9164	0.8692	-5.2%
120	5	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2577	2.4776	9.7%
121	5	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP, DISCH ALIVE	1.7687	1.7162	-3.0%
122	5	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP, DISCH ALIVE	1.3267	1.2002	-9.5%
123	5	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.3522	1.3979	3.4%
124	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2551	1.1806	-5.9%
125	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.7265	0.6884	-5.2%
126	5	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.9836	3.0575	2.5%
127	5	MED	HEART FAILURE & SHOCK	1.0098	1.0222	1.2%
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	0.8456	0.8513	0.7%
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.7199	1.5715	-8.6%
130	5	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	0.8251	0.8776	6.4%
131	5	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.6705	0.5862	-12.6%
132	5	MED	ATHEROSCLEROSIS WITH CC	0.8037	0.7976	-0.8%
133	5	MED	ATHEROSCLEROSIS W/O CC	0.7049	0.5997	-14.9%
134	5	MED	HYPERTENSION	0.6363	0.6088	-4.3%
135	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 WITH CC	0.8937	0.9221	3.2%
136	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	0.7525	0.6103	-18.9%
137	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.6315	0.6315	0.0%
138	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	0.8136	0.8535	4.9%
139	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6514	0.5912	-9.2%
140	5	MED	ANGINA PECTORIS	0.6894	0.6689	-3.0%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
141	5	MED	SYNCOPE & COLLAPSE WITH CC	0.6187	0.6801	9.9%
142	5	MED	SYNCOPE & COOLAPSE W/O CC	0.5335	0.5244	-1.7%
143	5	MED	CHEST PAIN	0.5893	0.5500	-6.7%
144	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	1.1160	1.1449	2.6%
145	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.8475	0.6689	-21.1%
146	6	SURG	RECTAL RESECTION WITH CC	3.0751	3.4379	11.8%
147	6	SURG	RECTAL RESECTION W/O CC	2.2735	2.1344	-6.1%
148	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	2.9401	3.2376	10.1%
149	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	2.1069	1.8341	-12.9%
150	6	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.3426	2.6797	14.4%
151	6	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.5900	1.4885	-6.4%
152	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.4059	1.5988	13.7%
153	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0992	1.0566	-3.9%
154	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 WITH CC	2.6876	3.7961	41.2%
155	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.7902	1.8195	1.6%
156	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8382	0.8382	0.0%
157	6	SURG	ANAL & STOMAL PROCEDURES WITH CC	0.7302	0.9324	27.7%
158	6	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.5511	0.5449	-1.1%
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC	0.9997	1.1454	14.6%
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.7457	0.6810	-8.7%
161	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC	0.6536	0.7541	15.4%
162	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.5261	0.5004	-4.9%
163	6	SURG	HERNIA PROCEDURES AGE 0-17	0.9647	0.7717	-20.0%
164	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.0646	2.4014	16.3%
165	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.4375	1.4675	2.1%
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.3604	1.4954	9.9%
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAL W/O CC	0.8872	0.8651	-2.5%
168	6	SURG	MOUTH PROCEDURES WITH CC	0.9182	1.4067	53.2%
169	6	SURG	MOUTH PROCEDURES W/O CC	0.6580	0.6689	1.7%
170	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7611	2.7316	-1.1%
171	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	2.3295	1.4018	-39.8%
172	6	MED	DIGESTIVE MALIGNANCY WITH CC	1.0748	1.1861	10.4%
173	6	MED	DIGESTIVE MALIGNANCY W/O CC	0.9602	0.7049	-26.6%
174	6	MED	G.I. HEMORRHAGE WITH CC	0.9073	0.9878	8.9%
175	6	MED	G.I. HEMORRHAGE W/O CC	0.7067	0.6600	-6.6%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
176	6	MED	COMPLICATED PEPTIC ULCER	0.9316	0.9964	7.0%
177	6	MED	UNCOMPLICATED PEPTIC ULCER WITH CC	0.6615	0.7834	18.4%
178	6	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.5554	0.5838	5.1%
179	6	MED	INFLAMMATORY BOWEL DISEASE	0.9875	1.0416	5.5%
180	6	MED	G.I. OBSTRUCTION WITH CC	0.7583	0.9150	20.7%
181	6	MED	G.I. OBSTRUCTION W/O CC	0.5827	0.5415	-7.1%
182	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC	0.6032	0.7224	19.8%
183	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5104	0.5252	2.9%
184	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4828	0.4223	-12.5%
185	6	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7147	0.7530	5.4%
186	6	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.4112	0.4112	0.0%
187	6	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.4209	0.4540	7.9%
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC	0.7171	0.9144	27.5%
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5260	0.4966	-5.6%
190	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.9178	0.8147	-11.2%
191	7	SURG	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	4.4603	4.6881	5.1%
192	7	SURG	MINOR PANCREAS, LIVER & SHUNT PROCEDURES	4.0437	3.8625	-4.5%
193	7	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY WITH CC	2.8115	3.0252	7.6%
194	7	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY W/O CC	2.1204	1.8505	-12.7%
195	7	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. WITH CC	2.2724	2.3854	5.0%
196	7	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. W/O CC	1.5974	1.6898	5.8%
197	7	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CC	1.7055	1.8768	10.0%
198	7	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1399	1.1152	-2.2%
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3379	2.2693	-2.9%
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.6281	2.4731	-5.9%
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7125	2.3933	-11.8%
202	7	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.1665	1.2075	3.5%
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0338	1.0422	0.8%
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9698	1.0269	5.9%
205	7	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA WITH CC	1.0718	1.2132	13.2%
206	7	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.7735	0.6806	-12.0%
207	7	MED	DISORDERS OF THE BILIARY TRACT WITH CC	0.7775	0.9243	18.9%
208	7	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.8793	0.5816	-33.9%
209	8	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES	2.3925	2.4145	0.9%
210	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC	2.0317	2.1776	7.2%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
211	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.7866	1.6104	-9.9%
212	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6608	1.3764	-17.1%
213	8	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.9750	1.8460	-6.5%
214	8	SURG	BACK & NECK PROCEDURES WITH CC	1.8749	2.1385	14.1%
215	8	SURG	BACK & NECK PROCEDURES W/O CC	1.4275	1.3768	-3.6%
216	8	SURG	BIOPSIES OF MUSCELOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.5565	1.5973	2.6%
217	8	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & TISS DIS	2.3097	2.8155	21.9%
218	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.3797	1.6224	17.6%
219	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.0436	1.0186	-2.4%
220	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	0.9242	0.9242	0.0%
221	8	SURG	KNEE PROCEDURES WITH CC	1.0141	1.4523	43.2%
222	8	SURG	KNEE PROCEDURES W/O CC	0.7262	0.7995	10.1%
223	8	SURG	MAJOR SHOULDER OR ELBOW PROC, OR OTHER UPPER EXTREMITY PROC, W CC	1.2263	1.1202	-8.7%
224	8	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.6894	0.6588	-4.4%
225	8	SURG	FOOT PROCEDURES	0.6552	0.6775	3.4%
226	8	SURG	SOFT TISSUE PROCEDURES WITH CC	0.8783	1.3570	54.5%
227	8	SURG	SOFT TISSUE PROCEDURES W/O CC	0.6673	0.6878	3.1%
228	8	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC, WITH CC	0.6100	0.8201	34.4%
229	8	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4993	0.5202	4.2%
230	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.0156	0.8868	-12.7%
231	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	0.7381	0.8346	13.1%
232	8	SURG	ARTHROSCOPY	0.6723	0.8603	28.0%
233	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.3898	1.7267	24.2%
234	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.9517	0.9057	-4.8%
235	8	MED	FRACTURES OF FEMUR	1.4136	1.2060	-14.7%
236	8	MED	FRACTURES OF HIP & PELVIS	1.0712	0.9036	-15.6%
237	8	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6049	0.5959	-1.5%
238	8	MED	OSTEOMYELITIS	1.6471	1.6579	0.7%
239	8	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.9268	0.9550	3.0%
240	8	MED	CONNECTIVE TISSUE DISORDERS WITH CC	0.9047	1.0932	20.8%
241	8	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.7463	0.6644	-11.0%
242	8	MED	SEPTIC ARTHRITIS	1.4562	1.4100	-3.2%
243	8	MED	MEDICAL BACK PROBLEMS	0.6840	0.6694	-2.1%
244	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	0.6742	0.7305	8.4%
245	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.6400	0.5345	-16.5%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
246	8	MED	NON-SPECIFIC ARTHROPATHIES	0.5935	0.5769	-2.8%
247	8	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5793	0.5407	-6.7%
248	8	MED	TENDONITIS MYOSITIS & BURSITIS	0.5892	0.6097	3.5%
249	8	MED	AFTERCARE MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7875	0.6830	-13.3%
250	8	MED	FX, SPRN, STRNS & DISL OF FOREARM HAND FOOT AGE >17 WITH CC	0.5158	0.6721	30.3%
251	8	MED	FX, SPRN, STRNS & DISL OF FOREARM HAND FOOT AGE >17 W/O CC	0.4003	0.4148	3.6%
252	8	MED	FX, SPRN, STRNS & DISL OF UPARM LOWLEG EX FOOT AGE 0-17	0.3496	0.3496	0.0%
253	8	MED	FX, SPRN, STRNS & DISL OF WPARM LOWLEG EX FOOT AGE >17 WITH CC	0.6321	0.7909	25.1%
254	8	MED	FX, SPRN, STRNS & DISL OF WPARM LOWLEG EX FOOT AGE >17 W/O CC	0.4929	0.4557	-7.5%
255	8	MED	FX, SPRN, STRNS & DISL OR UPARM LOWLEG EX FOOT AGE 0-17	0.4638	0.4638	0.0%
256	8	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.6991	0.6585	-5.8%
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	1.0630	1.0448	-1.7%
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.9696	0.8462	-12.7%
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	0.8605	1.0046	16.7%
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6659	0.6010	-9.7%
261	9	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.6104	0.6204	1.6%
262	9	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.4252	0.4312	1.4%
263	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC	2.4173	2.5967	7.4%
264	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	2.1798	1.6179	-25.8%
265	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.3967	1.3909	-0.4%
266	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7313	0.6865	-6.1%
267	9	SURG	PERIANAL & PILONIDAL PROCEDURES	0.6360	0.6248	-1.8%
268	9	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	0.5657	0.5934	4.9%
269	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH CC	1.1334	1.5177	33.9%
270	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC W/O CC	0.7622	0.6834	-10.3%
271	9	MED	SKIN ULCERS	1.2612	1.2017	-4.7%
272	9	MED	MAJOR SKIN DISORDERS WITH CC	0.8524	1.0375	21.7%
273	9	MED	MAJOR SKIN DISORDERS W/O CC	0.7971	0.7247	-9.1%
274	9	MED	MALIGNANT BREAST DISORDERS WITH CC	1.0367	1.0494	1.2%
275	9	MED	MALIGNANT BREAST DISORDERS W/O CC	0.9880	0.6395	-35.3%
276	9	MED	NON-MALIGNAT BREAST DISORDERS	0.5677	0.5245	-7.6%
277	9	MED	CELLULITIS AGE >17 WITH CC	0.8861	0.9695	9.4%
278	9	MED	CELLULITIS AGE >17 W/O CC	0.7582	0.7063	-6.8%
279	9	MED	CELLULITIS AGE 0-17	0.4739	0.7367	55.5%
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	0.5414	0.6197	14.5%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
281	9	MED	TRAUMA TO THE SKIN SUBCUT TISS & BREAST AGE >17 W/O CC	0.4467	0.4306	-3.6%
282	9	MED	TRAUMA TO THE SKIN SUBCUT TISS & BREAST AGE 0-17	0.3424	0.3424	0.0%
283	9	MED	MINOR SKIN DISORDERS WITH CC	0.6365	0.7682	20.7%
284	9	MED	MINOR SKIN DISORDERS W/O CC	0.5170	0.4795	-7.3%
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOC., NUTRIT, & METABOL DISORDERS	3.2719	2.9919	-8.6%
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.6727	2.7063	1.3%
287	10	SURG	SKIN GRAFTS & WOUNDS DEBRID FOR ENDOC, NUTRIT, & METAB DISORDERS	2.3776	2.2274	-6.3%
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1128	2.0018	-5.3%
289	10	SURG	PARATHYROID PROCEDURES	1.3304	1.1470	-13.8%
290	10	SURG	THYROID PROCEDURES	0.8561	0.8428	-1.6%
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6072	0.4991	-17.8%
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.3129	2.6027	12.5%
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.7960	1.1698	-34.9%
294	10	MED	DIABETES AGE >35	0.7454	0.7493	0.5%
295	10	MED	DIABETES AGE 0-35	0.7886	0.7228	-8.3%
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	0.8271	0.9259	11.9%
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6984	0.5791	-17.1%
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.7203	0.7065	-1.9%
299	10	MED	INBORN ERROR OF METABOLISM	0.8041	0.8271	2.9%
300	10	MED	ENDOCRINE DISORDERS WITH CC	0.9348	1.0862	16.2%
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6882	0.6758	-1.8%
302	11	SURG	KIDNEY TRANSPLANT	4.6267	3.8463	-16.9%
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.7606	2.7747	0.5%
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.0322	2.3651	16.4%
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.4893	1.3665	-8.2%
306	11	SURG	PROSTATECTOMY WITH CC	1.2593	1.4376	14.2%
307	11	SURG	PROSTATECTOMY W/O CC	0.9585	0.9121	-4.8%
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.1487	1.5354	33.7%
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.8644	0.8620	-0.3%
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	0.7265	0.9026	24.2%
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.5564	0.5681	2.1%
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	0.7307	0.8246	12.9%
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.5804	0.5286	-8.9%
314	11	SURG	URETHRAL PROCEDURES, AGE 0-17	0.4323	0.4323	0.0%
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.7736	2.3635	-14.8%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
316	11	MED	RENAL FAILURE	1.3210	1.2840	-2.8%
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.4907	0.3542	-27.8%
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS WITH CC	0.9216	1.0441	13.3%
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7415	0.5777	-22.1%
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	0.8626	1.0230	18.6%
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6750	0.7316	8.4%
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.6996	0.6829	-2.4%
323	11	MED	URINARY STONES WITH CC &/OR ESW LITHOTRIPSY	0.5862	0.7020	19.8%
324	11	MED	URINARY STONE W/O CC	0.4096	0.5139	25.5%
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	0.6503	0.6789	4.4%
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.5156	0.4553	-11.7%
327	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.5511	0.5511	0.0%
328	11	MED	URETHRAL STRICTURE AGE >17 WITH CC	0.5939	0.6266	5.5%
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.4870	0.4431	-9.0%
330	11	MED	URETHRAL STRICUTURE AGE 0-17	0.2788	0.2788	0.0%
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	0.8329	0.9050	8.7%
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6725	0.5913	-12.1%
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.7912	0.6887	-13.0%
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH CC	1.8035	1.9237	6.7%
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.4643	1.4080	-3.8%
336	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC	0.9869	1.0774	9.2%
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.7788	0.7505	-3.6%
338	12	SURG	TESTES PROCEDURES FOR MALIGNANCY	0.8907	0.7865	-11.7%
339	12	SURG	TESTES PROCEDURES FOR NON-MALIGNANCY AGE >17	0.5766	0.5930	2.8%
340	12	SURG	TESTES PROCEDURES FOR NON-MALIGNANCY AGE 0-17	0.4335	0.4335	0.0%
341	12	SURG	PENIS PROCEDURES	0.9970	1.0294	3.2%
342	12	SURG	CIRCUMCISION AGE >17	0.4265	0.4494	5.4%
343	12	SURG	CIRCUMCISION AGE 0-17	0.3788	0.3788	0.0%
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1214	1.1302	0.8%
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	0.8173	0.8284	1.4%
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	0.8568	0.9360	9.2%
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.6441	0.5091	-21.0%
348	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH CC	0.6257	0.6588	5.3%
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4853	0.4059	-16.4%
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6270	0.6734	7.4%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
351	12	MED	STERILIZATION, MALE	0.3333	0.3333	0.0%
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.5354	0.4886	-8.7%
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.3887	2.2997	-3.7%
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.3563	1.5482	14.1%
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.0359	0.9929	-4.2%
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.8470	0.7983	-5.7%
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.1103	2.1591	2.3%
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.1152	1.2941	16.0%
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.9462	0.9025	-4.6%
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.6338	0.6957	9.8%
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.6594	0.6442	-2.3%
362	13	SURG	ENDOSCOPIC TUBAL INTERRUPTION	0.3510	0.4095	16.7%
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT FOR MALIGNANCY	0.6156	0.6597	7.2%
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.3921	0.4262	8.7%
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9085	1.9060	-0.1%
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	0.8624	1.0916	26.6%
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5353	0.5481	2.4%
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7610	0.8308	9.2%
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.5496	0.4920	-10.5%
370	14	SURG	CESAREAN SECTION WITH CC	1.1063	1.0303	-6.9%
371	14	SURG	CESAREAN SECTION W/O CC	0.7669	0.7164	-6.6%
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5942	0.4927	-17.1%
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3538	0.3212	-9.2%
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.5754	0.5641	-2.0%
375	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.6817	0.6817	0.0%
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4539	0.3520	-22.4%
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES WITH O.R. PROCEDURE	0.7698	0.9882	28.4%
378	14	MED	ECTOPIC PREGNANCY	0.7357	0.7787	5.8%
379	14	MED	THREATENED ABORTION	0.2409	0.2843	18.0%
380	14	MED	ABORTION W/O D&C	0.3792	0.3124	-17.6%
381	14	MED	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.3725	0.3694	-0.8%
382	14	MED	FALSE LABOR	0.1136	0.1309	15.2%
383	14	MED	OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	0.4452	0.3964	-11.0%
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4586	0.3512	-23.4%
385	15		NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.6811	1.2232	79.6%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
386	15		EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480	3.6480	0.0%
387	15		PREMATURITY WITH MAJOR PROBLEMS	1.8267	1.8267	0.0%
388	15		PREMATURITY W/O MAJOR PROBLEMS	1.1571	1.1571	0.0%
389	15		FULL TERM NEONATE WITH MAJOR PROBLEMS	0.5425	1.4127	160.4%
390	15		NEONATE WITH OTHER SIGNIFICANT PROBLEMS	0.3486	0.9416	170.1%
391	15		NORMAL NEWBORN	0.2218	0.2218	0.0%
392	16	SURG	SPLENECTOMY AGE >17	3.2488	3.5252	8.5%
393	16	SURG	SPLENECTOMY AGE 0-17	1.5206	1.5206	0.0%
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.0889	1.2250	12.5%
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.7153	0.7264	1.6%
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.2952	0.3441	16.6%
397	16	MED	COAGULATION DISORDERS	0.9969	1.0145	1.8%
398	16	MED	RETICULDENDOTHELIAL & IMMUNITY DISORDERS WITH CC	0.9752	1.2115	24.2%
399	16	MED	RETICULDENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.7247	0.6830	-5.8%
400	17	SURG	LYMPHOMA & LEUKEMIA WITH MAJOR O.R. PROCUDURE	3.1139	2.6900	-13.6%
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA WITH OTHER O.R. PROC WITH CC	1.9327	2.0871	8.0%
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA WITH OTHER O.R. PROC W/O CC	1.0514	0.9252	-12.0%
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA WITH CC	1.3493	1.5222	12.8%
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.9101	0.8085	-11.2%
405	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0407	1.0407	0.0%
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC WITH CC	2.5302	2.7146	7.3%
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	1.7124	1.4499	-15.3%
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R. PROC	1.0500	0.8955	-14.7%
409	17	MED	RADIOTHERAPY	0.9855	1.0802	9.6%
410	17	MED	CHEMOTHERAPY	0.4284	0.4742	10.7%
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5907	0.4919	-16.7%
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	0.3388	0.3954	16.7%
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.0455	1.2385	18.5%
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.8983	0.8128	-9.5%
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.3287	3.5067	5.3%
416	18	MED	SEPTECEMIA AGE >17	1.6182	1.5894	-1.8%
417	18	MED	SEPTECEMIA AGE 0-17	1.1530	0.9346	-18.9%
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0022	0.9743	-2.8%
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	0.9305	0.9778	5.1%
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.8316	0.6949	-16.4%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
421	18	MED	VIRAL ILLNESS AGE >17	0.5672	0.6255	10.3%
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6583	0.6274	-4.7%
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.3205	1.5333	16.1%
424	19	SURG	O.R. PROCEDURE WITH PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.2113	2.2176	0.3%
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	0.6090	0.6004	-1.4%
426	19	MED	DEPRESSIVE NEUROSES	0.8332	0.6580	-21.0%
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7018	0.6315	-10.0%
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.8513	0.7305	-14.2%
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8419	0.8868	5.3%
430	19	MED	PSYCHOSES	1.0760	0.9329	-13.3%
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.6493	0.7134	9.9%
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6968	0.7097	1.9%
433	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3906	0.4232	8.3%
434	20		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	0.7096	0.8149	14.8%
435	20		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	0.7978	0.5903	-26.0%
436	20		ALC/DRUG DEPENDENCE WITH REHABILITATION THERAPY	1.0166	0.9788	-3.7%
437	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	1.3273	1.3306	0.2%
438	20		NO LONGER VALID	0.0000	0.0000	NA
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.6505	1.7523	6.2%
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0421	2.2498	10.2%
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.7303	0.7185	-1.6%
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.8143	1.9218	5.9%
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.4841	1.2169	-18.0%
444	21	MED	MULTIPLE TRAUMA AGE >17 WITH CC	0.7072	0.8207	16.0%
445	21	MED	MULTIPLE TRAUMA AGE >17 W/O CC	0.6014	0.5183	-13.8%
446	21	MED	MULTIPLE TRAUMA AGE 0-17	0.4796	0.4796	0.0%
447	21	MED	ALLERGIC REACTIONS AGE >17	0.4470	0.4703	5.2%
448	21	MED	ALLERGIC REACTIONS AGE 0-17	0.3470	0.3470	0.0%
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	0.6951	0.7922	14.0%
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.5422	0.4917	-9.3%
451	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.5497	0.5907	7.5%
452	21	MED	COMPLICATIONS OF TREATMENT WITH CC	0.8079	0.8976	11.1%
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.7468	0.5137	-31.2%
454	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	0.8099	0.9067	12.0%
455	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	0.6002	0.4692	-21.8%

Appendix C. Change in DRG Weights From Fiscal Year 1987 to Fiscal Year 1988.

DRG	MDC	TYPE	TITLE	FY87 WEIGHT	FY88 WEIGHT	WEIGHT CHANGE
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.8155	1.9811	9.1%
457	22		EXTENSIVE BURNS W/O O.R. PROCEDURE	3.2280	2.5317	-21.6%
458	22	SURG	NON-EXTENSIVE BURNS WITH SKIN GRAFT	3.9450	3.7113	-5.9%
459	22	SURG	NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT OR OTHER O.R. PROC	3.2658	1.7964	-45.0%
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.1592	1.0495	-9.5%
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.3548	0.7198	-46.9%
462	23	MED	REHABILITATION	2.1404	1.7517	-18.2%
463	23	MED	SIGNS & SYMPTOMS WITH CC	0.7949	0.7633	-4.0%
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.6952	0.4740	-31.8%
465	23	MED	AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.2881	0.3172	10.1%
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.4152	0.5383	29.6%
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7212	0.4723	-34.5%
468			UNRELATED OPERATING ROOM PROCEDURES	2.4516	2.4679	0.7%
469			PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0000	NA
470			UNGROUPABLE	0.0000	0.0000	NA
471	8	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.6991	4.0896	10.6%
472	22	SURG	EXTENSIVE BURNS WITH O.R. PROCEDURE	12.3234	10.7296	-12.9%
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	2.3275	2.7107	16.5%
474	4		TRACHEOSTOMY	NA	11.8772	NA
475	4	MED	MECHANICAL VENTILATION THROUGH ENDOTRACHIAL INTUBATION	NA	3.1757	NA

APPENDIX D

BIOGRAPHICAL SKETCHES OF COMMISSIONERS

Stuart H. Altman, Chairman

Stuart H. Altman, dean of the Florence Heller Graduate School for Social Policy, Brandeis University, and Sol C. Chaikin Professor of National Health Policy, is an economist whose research interests are primarily in the area of Federal health policy. He has been at Brandeis since 1977. Between 1971 and 1976, Dean Altman was deputy assistant secretary for planning and evaluation/health at the Department of Health, Education and Welfare (now the Department of Health and Human Services). In that position, he was one of the primary contributors to the development and advancement of the National Health Insurance proposal. From 1973 to 1974, he also served as the deputy director for health of the president's Cost of Living Council, where he was responsible for developing the council's program on health care cost-containment. Formerly, Dean Altman taught at Brown University and at the University of California (Berkeley). He is a member of the Institute of Medicine of the National Academy of Sciences and former member of its governing council; on the board of Beth Israel Hospital (Boston); chairman of the board of the Health Policy Center at Brandeis; and president of the National Foundation for Health Services Research. He is a past president of the National Association for Health Services Research and former board member of the Robert Wood Johnson Clinical Scholars Program. Dean Altman also served on the president's Commission for a National Agenda for the Eighties. A member of several editorial boards, he has published extensively on various aspects of health care and public policy. His recent publications include: the Arthur Weissman Memorial Lecture, "Will the Medicare Prospective Payment System Succeed? Technical Adjustments Can Make the Difference,"; Federal Health Policy: Problems and Prospects, with Harvey M. Sapolsky; Ambulatory Care: Problems of Cost and Access, with Joanna Lion and Judith LaVor Williams; "Financing Hospital Care: An Uncertain Future," Journal of Health Administration and Education, Winter, Vol. 3, No. 1, 1985; "The Impact of Cost Shifting on the Health Care System," in Health Care Commentary, Health Insurance Association of America; and "The Growing Physician Surplus: Will it Bankrupt or Benefit the U.S. Health System?" in In Search of a Public Policy, edited by Eli Ginzberg and Miriam Ostow. Dean Altman received both an M.S. and a Ph.D. in economics from the University of California (Los Angeles).

Harold A. Cohen

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William D. Fullerton is an adjunct associate professor in the School of Medicine, University of North Carolina at Chapel Hill. From 1978 to 1984, he was principal and president of Health Policy Alternatives, Inc., where he is now a part-time consultant. The first deputy administrator of the Health Care Financing Administration (1977-1978), Mr. Fullerton was also a special consultant to the Secretary of the Department of Health, Education, and Welfare. He served as chief of the professional health staff, Committee on Ways and Means, U.S. House of Representatives, from 1970 to 1976. Mr. Fullerton was the first executive secretary of the Health Insurance Benefits Advisory Council in 1965-66. Before that, he held various positions in the Social Security

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Kathryn M. Mershon

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James J. Mongan

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Eric Muñoz

Eric Muñoz is head of the research division of the department of surgery at the Long Island Jewish-Hillside Medical Center, and assistant professor of surgery at State University of New York at Stony Brook. He has been an instructor at the Yale University School of Medicine and New York Medical College. Dr. Muñoz is nationally recognized for his research on the DRG payment mechanism, which has focused on the higher costs of emergency hospital admissions. He is also a specialist on problems of health care delivery to the poor. Dr. Muñoz was president of the American Association of Puerto Rican Scientists and served on the board of that organization. His other numerous professional affiliations include Fellow of the American College of Surgeons, the Association for Academic Surgery, and the International Health Economics and Management Institute. He is certified by the American Board of Surgery. Dr. Muñoz has published more than 30 articles on

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John C. Nelson

John C. Nelson is a practicing obstetrician and gynecologist in Salt Lake City, Utah. He has been involved in cost-containment efforts at local and state levels and is active in the American Cancer Society and numerous other medical and civic efforts. A member of the American Medical Association, Dr. Nelson is the delegate from Utah and serves on the work group on evaluation, assessment, and control--Health Policy Agenda for the American People. He is a delegate to the Utah State Medical Association House of Delegates, and serves on the editorial board of the Utah Medical Bulletin as well as on the board of the Utah Health Cost Management Foundation. Dr. Nelson is also a member of the board of the Utah Professional Review Organization and the governor's Select Advisory Committee on Child Abuse and Neglect. He is former director of cost-containment for Blue Cross/Blue Shield of Utah. Dr. Nelson took his internship at the Providence Hospital in Portland, Oregon, and a residency with the Department of Obstetrics and Gynecology at the University of Utah. He is board-certified by the American Board of Obstetrics and Gynecology, and a Fellow of the American College of Obstetrics and Gynecology. He received his bachelor's degree in zoology from Utah State University and his M.D. from the Utah College of Medicine.

Leonard D. Schaeffer

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Bert Seidman

Bert Seidman has been the director of the Department of Occupational Safety, Health and Social Security of the AFL-CIO, Washington, D.C., since 1983. From 1962 to 1966, he was the AFL-CIO European economic representative stationed in Paris and then in Geneva. Before that, he served for 14 years as an economist in the research department of the AFL and the AFL-CIO. In 1966, he became director of the AFL-CIO Social Security Department. He was a member of the U.S. labor delegation to the annual conference of the

International Labor Organization (ILO) from 1958 to 1976 and, from 1972 to 1975, was a member of the ILO governing body. In 1973 and 1974, he was the U.S. worker delegate to the ILO conference. He has served on numerous committees, including the Federal Advisory Council on Employment Security, the Advisory Council on Health Insurance for the Disabled, the Task Force on Medicaid and Related Programs, the Advisory Council on Social Security, the Federal Hospital Council, the Health Insurance Benefits Advisory Council, the Blue Cross Advisory Committee, and the 1981 White House Conference on Aging (the Advisory Committee and chairman of the Technical Committee on Retirement Income). At present, he is a member of the HMO Industry Council, the Brookings Institution Advisory Panel on Long-Term Care, and the National Advisory Committee to the Robert Wood Johnson Foundation on Community Programs for Affordable Health Care. He is on the board of the National Council of Senior Citizens and the National Council on Aging, and is a vice president of the National Consumers League.

Jack K. Shelton

Jack K. Shelton is manager of the Employee Insurance Department of the Ford Motor Company, which he joined in 1956. He is responsible for the financial control and analysis of nearly all employee benefit plans. In this capacity, he participates in union negotiations, relations with insurance carriers, and financial control of company-administered plans. He also reviews changes in wage and benefit programs for foreign subsidiaries. Mr. Shelton is actively involved in a number of local and national health care organizations, serving as a director of the National Fund for Medical Education, a director of Blue Cross and Blue Shield of Michigan, and a member of the Statewide Health Coordinating Council of Michigan. In 1985, he was a member of an Office of Technology Assessment Advisory Panel on Alternative Physician Payments for Medicare and chairman of the Employer Prospective Payment Advisory Commission for the Washington Business Group on Health. He is past chairman of the National Industry Council on HMO Development, the Michigan Health Economics Coalition, the Michigan Hospital Capacity Reduction Corporation, and the Health Alliance Plan (Michigan's largest HMO). Mr. Shelton received his B.S. and M.S. degrees in industrial psychology from Oklahoma State University.

Bruce C. Vladeck

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